DOCUMENT RESUME

ED 041 416 EC 005 829

TITLE	New York State Comprehensive Planning for Vocational Rehabilitation Services. Volume II, Regional Reports.
INSTITUTION	State Univ. of New York, Albany. State Educational Dept.
SPONS AGENCY	Rehabilitation Services Administration (DHEW), Washington, D.C.
PUB DATE	Jul 69
NOTE	334p.
EDRS PRICE	EDRS Price MF-$1.25 HC-$16.80
DESCRIPTORS	Community Services, Educational Facilities, *Exceptional Child Services, *Handicapped, Planning Commissions, Regional Planning, *Rehabilitation Programs, State Programs, *Vocational Rehabilitation
IDENTIFIERS	New York

ABSTRACT

Volume 2 of the New York State Plan for Comprehensive Rehabilitation Services contains the reports of the four Regional Advisory Committees, whose recommendations provide the basis upon which the final State Plan (Volume I) was developed. Each report examines present capability and unmet needs, and offers recommendations related to the development, expansion, and delivery of vocational rehabilitation programs to serve all handicapped persons in that region. Topics discussed in individual reports include: planning organization and method of operation, disability reports (physical and mental handicaps, and social and cultural disadvantagement) recommendations, funding, manpower, facilities and workshops, legislation, and administration and coordination. Volume I is available as EC 005 828. (KW)

ED 041416

STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION SERVICES IN NEW YORK STATE

Volume 2
Regional Reports

ACCESS
to
OPPORTUNITY

Regents of the
University of the
State of New York

EC 005 82E

ED041416

NEW YORK STATE
COMPREHENSIVE PLANNING
for
VOCATIONAL REHABILITATION SERVICES

VOLUME II

REGIONAL REPORTS

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

Regents of the
University of the State of New York

Inclusive Period of Planning Project
7/21/67 - 7/21/69

July 31, 1969

THE UNIVERSITY OF THE STATE OF NEW YORK

Regents of the University (with years when terms expire)

1984	Joseph W. McGovern, A.B., LL.B., L.H.D., LL.D., Chancellor	New York
1970	Everett J. Penny, B.C.S., D.C.S., Vice Chancellor	White Plains
1978	Alexander J. Allan, Jr., LL.D., Litt.D.	Troy
1973	Charles W. Millard, Jr., A.B., LL.D., L.H.D.	Buffalo
1972	Carl H. Pforzheimer, Jr., A.B., M.B.A., D.C.S., H.H.D.	Purchase
1975	Edward M.M. Warburg, B.S., L.H.D.	New York
1977	Joseph T. King, LL.B.	Queens
1974	Joseph C. Indelicato, M.D.	Brooklyn
1976	Mrs. Helen B. Power, A.B., Litt, D., L.H.D.	Rochester
1979	Francis W. McGinley, B.S., LL.B., LL.D.	Glens Falls
1980	Max Rubin, LL.B., L.H.D.	New York
1971	Kenneth B. Clark, A.B., M.S., Ph.D., Litt.D.	Hastings on Hudson
1982	Stephen K. Bailey, A.B., B.A., M.A., Ph.D., LL.D.	Syracuse
1983	Harold E. Newcomb, B.A.	Owego
1981	Theodore M. Black, B.A.	Sands Point

President of the University and Commissioner of Education (Acting)

Ewald B. Nyquist

Assistant Commissioner for Vocational Rehabilitation

Adrian Levy

Project Director, Office of Statewide Planning for Vocational Rehabilitation Services

Sol Richman

FOREWORD

Volume II of the New York State Plan for Comprehensive Vocational Rehabilitation Services contains the reports prepared by the 4 Regional Advisory Committees which were representative of every county in New York State.

Some 700 persons participated in the 4 Regional and 18 District Advisory Committees - reviewing, evaluating and planning rehabilitation programs. Representatives of public and private agencies, professional and civic groups, management, labor, community action and minority groups, the consumer of services and the citizens interested in rehabilitation responded eagerly to participate in the planning process within and for their communities. Thus the stage for effective community involvement with the will to implement throughout the State was established.

The Advisory Committee members examined their communitys' service capability and unmet needs. Through innovative ideas and creative approaches tailored to their area and yet translatable to the whole State, they established the community's responsibility for a continuum of services, emphasized the importance of service continuity and gave new dimensions to the practice of vocational rehabilitation in scope and philosophy.

Their deep concern for the severely disabled and the disadvantaged and the service and delivery systems they recommended, is epitomized in the theme of the State Plan brochure Access to Opportunity. In concept, these terms posit that self-realization, in part expressed in effort in a job, school or home derives from two interrelated factors namely, "accessibility" or identification with society's values and "opportunity" or the use of society's social instrumentalities to achieve a goal, a level of contribution through work. "Access" further discribes a mental set that expresses confidence in one's self and in society and is the catalyst that makes "opportunity" meaningful and usable. These concepts are the keystone to rehabilitation practice and process.

Perhaps this principle is expressed more cogently in the words of former President Lyndon Johnson, who in a foreword to the Negro American said:

> "You do not take a person who for years has been hobbled by chains and liberate him, bring him up to the starting line of a race, and say, 'you are free to compete with all others', and still justly believe that you have been completely fair.
>
> This is not enough to open the gates of opportunity. All our citizens must have the ability to walk through those gates."[1]

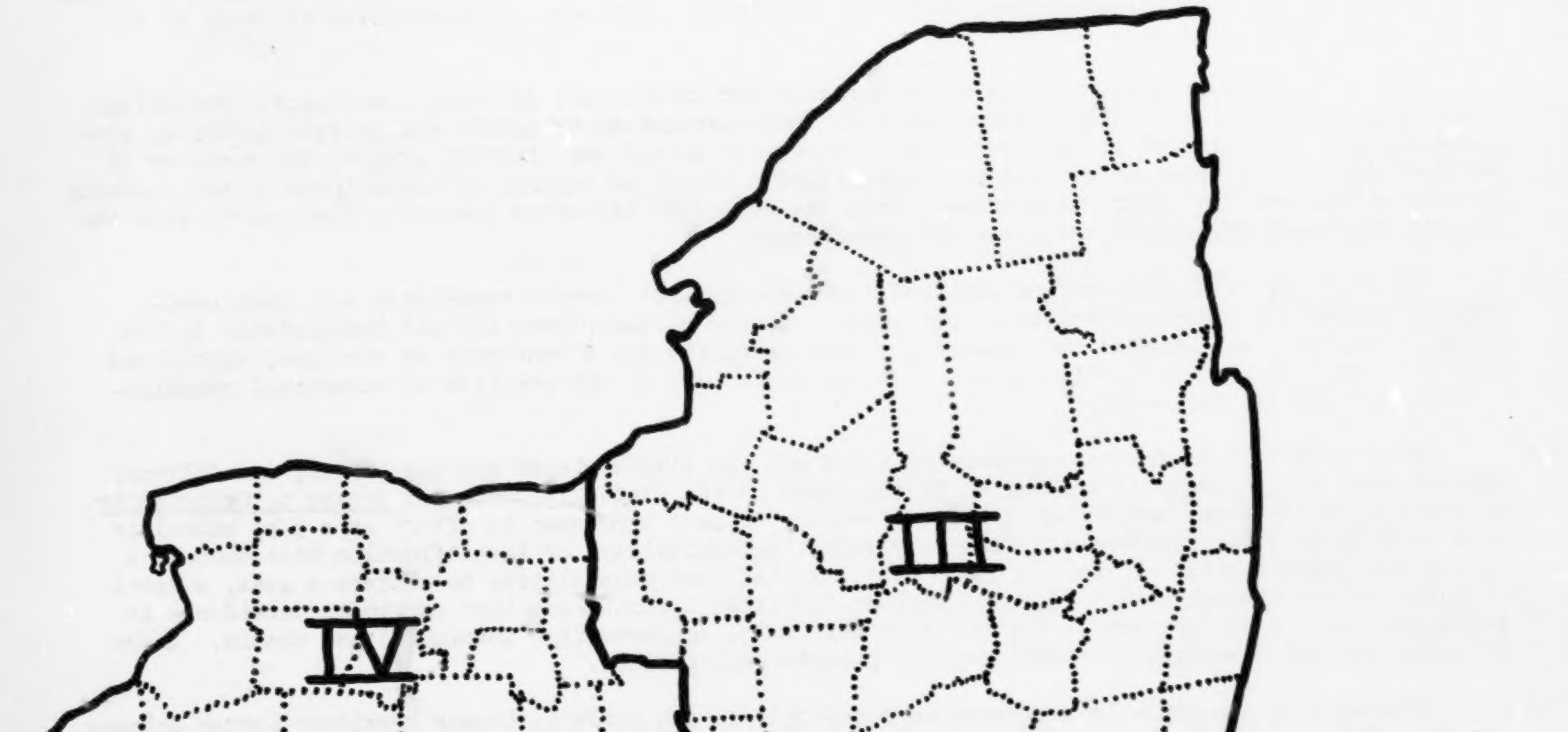
The four reports which follow provide the basic recommendations upon which the final State Plan, Volume I, is developed. These recommendations are not a detailed blueprint but give direction to orderly development and expansion and delivery of rehabilitation programs able to serve all handicapped persons.

A variety of efforts will be required to provide expanded rehabilitation services. With the will to begin and the necessary support available, New York State will respond affirmatively to Governor Nelson A. Rockefeller's charge to "serve all the handicapped."

Sol Richman
Project Director

---

[1] Daedalus, The Negro American: Journal of the Academy of Arts and Sciences, Fall 1965, pg. 743.


III
IV
II
I

OFFICE OF STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION SERVICES

STAFF

Sol Richman, Project Director

Raymond S. Klein Research Director	Louise Tornatore Assistant Research Director

Raymond Osterhout*
Statewide Specialist for the Blind

David Wolf*	Assistant Research Director
Sally Davis**	Research Analyst
Pat Nelson	Research Analyst
Pamela Corrento*	Research Analyst
Leta Cousins	Senior Secretary
Sandra Politano***	Senior Secretary
Susan Petrecky*	Statistical Clerk
Helen Holes**	Secretary
Donna Sheehy	Secretary
Michele Carrello	Typist
Margaret Grovesten	Typist

Regional Offices

Region I

Henry Marquit, Regional Planning Director
Valarie Darienzo, Secretary

Region II

Elizabeth Anderson, Regional Planning Director
Carol Walker, Secretary
Linda Blackson, Secretary*

Region III

Katherine Broughton, Regional Planning Director
Rose Scisci, Secretary
Ellen Kilmer, Secretary*

Region IV

Isabel Boner, Regional Planning Director
Gertrude Siebert, Secretary

* Resigned during project
** Part Time
*** On Leave

"This planning program was supported in part by a grant, under Section 4 (a) (2) (b), from the Rehabilitation Services Administration, Social and Rehabilitation Service, Department of Health, Education and Welfare, Washington, D.C."

"DISCRIMINATION PROHIBITED--Title VI of the Civil Rights Act of 1964 states: 'No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.' Therefore, all programs and activities receiving financial assistance from the Department of Health, Education and Welfare must be operated in compliance with this law."

LIST OF REGIONAL REPORTS

Volume II consists of four reports developed and submitted by the four Regional Advisory Committees. Below is a listing of the counties comprising each of the four Regions. Individuals who participated in the development of these reports are listed separately within each Regional Report. Each report assesses current capability, reflects unmet needs and concerns, and offers recommendations towards meeting the comprehensive vocational rehabilitation needs in the Region. This material has been used as the primary resource for the development of Volume I.

REGION I REPORT 1

REGION II REPORT 149

REGION III REPORT 244

REGION IV REPORT 308

REPORT

of

REGIONAL ADVISORY COMMITTEE

REGION I

Bronx - Kings - New York - Queens - Richmond
(New York City)

University of the State of New York
State Education Department
Office of Statewide Planning for Vocational Rehabilitation Services

January 1969

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
OFFICE FOR STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION SERVICES
225 PARK AVENUE SOUTH - ROOM 1301, NEW YORK, NEW YORK 10003

REGION I ADVISORY COMMITTEE

W. WALTER WATTS, CHAIRMAN
BERTRAM BLACK, VICE CHAIRMAN
E. PAUL FITZ GERALD, ASSISTANT TO CHAIRMAN

HENRY MARQUIT
REGIONAL PLANNING DIRECTOR

January 28, 1969

Mr. Sol Richman, Director
Office of Planning for Vocational
Rehabilitation Services
New York State Education Department
162 Washington Avenue
Albany, New York 12210

Dear Sol:

When I was asked by State Education Commissioner James E. Allen to undertake the task of chairing the Region I Advisory Committee for Vocational Rehabilitation Planning I had no concept of the job to be done nor the multitude of interested agencies, public and private, concerned with this work. Furthermore, I soon found that there were many forceful opinions held by individuals on what ought to be done to make vocational rehabilitation more effective.

As the meetings were held and minutes, reports and supplementary documents reviewed, I came to have an appreciation of the deep dedication the planners brought to this work. Strengths were evidenced upon which great results could be achieved. The broad understanding of everyone concerned for the legislative, political, competitive and operating problems involved greatly simplified the task of being objective in formulating specific recommendations that are aimed at surmounting the present cumbersome system of duplicating and overlapping programs. To a very large extent, I believe, personal and vested interests have been set aside. The client-consumer has been given primary consideration in our deliberations.

We submit herewith "Major Rehabilitation Needs and Goals in New York City," the report of the Region I Advisory Committee, with the conviction that we have carried out the charge that was given to us at the onset. The report examines basic concepts in present governmental and voluntary organization patterns and raises questions that may well indicate a need for far-reaching elemental changes in these patterns over the next decade.

May I make a fervent plea that provision be made for a small on-going advisory group to be constituted, perhaps as an extension of the present committee, to provide for monitoring and advice to all parties concerned in respect to the program and actions on the recommendations as finally adopted.

New York City's Mayor, John V. Lindsay, has, as Honorary Chairman of this committee, given his encouragement and lent the weight of his office to our planning. The Mayor has my personal gratitude and that of the entire committee.

The attached work could not have been completed without the invaluable guidance and counsel given to me personally and to the committee by my Vice Chairman, Professor Bertram Black, and my assistant, Mr. Paul Fitz Gerald, In addition, I would like to acknowledge the splendid work of Mr. Henry Marquit, our Staff Director, and the thoughtful assistance which you yourself have given at every stage of the work.

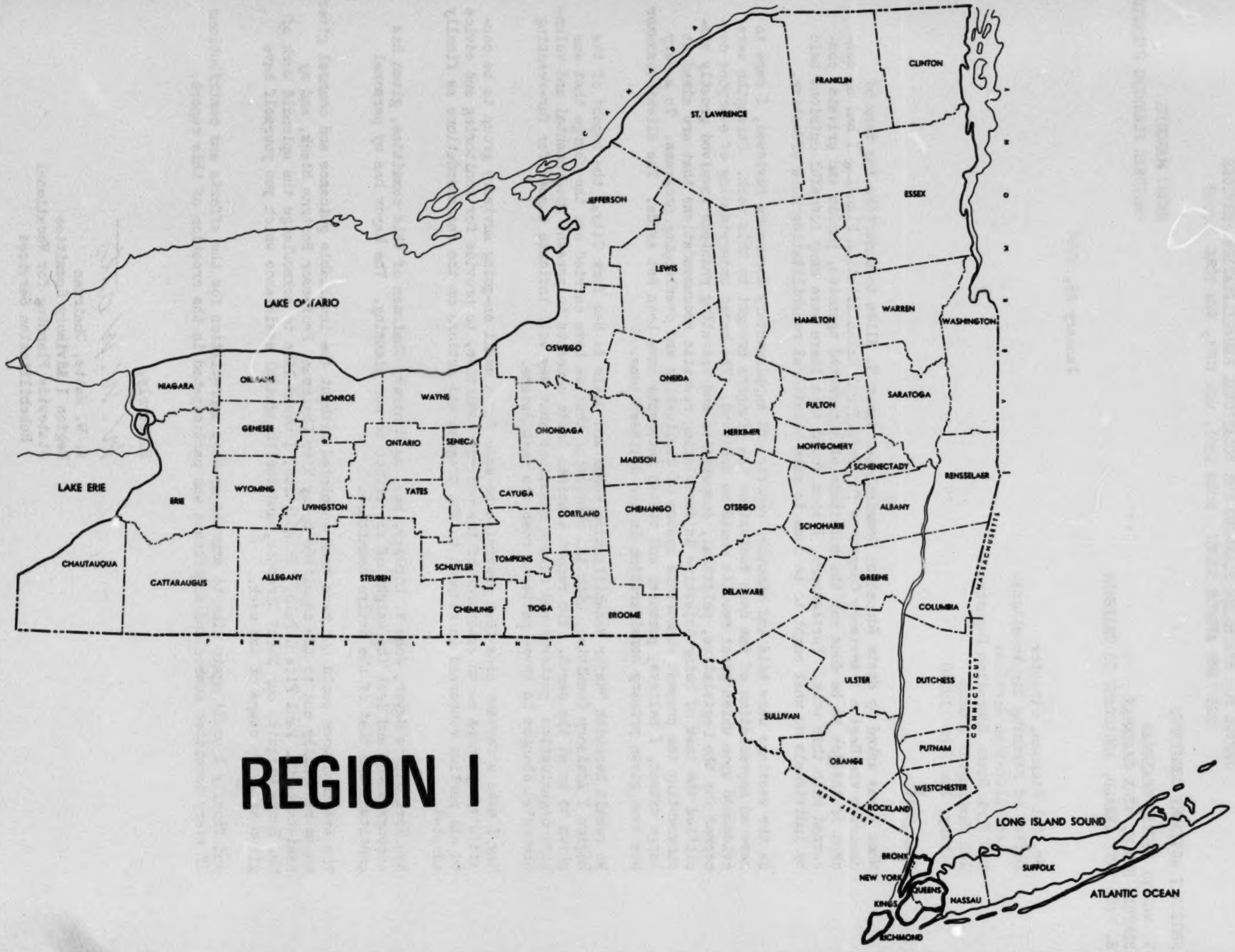
And finally I would again like to express my deep appreciation for the efforts and contributions of every committee member and consultant who participated in the creation of this report.

Sincerely,

W. W. Watts

W. W. Watts, Chairman
Region I Advisory Committee
Statewide Planning for Vocational
Rehabilitation Services

2/3



REGION I

LAKE ONTARIO
LAKE ERIE
NIAGARA
ORLEANS
MONROE
WAYNE
GENESEE
ONTARIO
SENECA
WYOMING
LIVINGSTON
YATES
ERIE
CHAUTAUQUA
CATTARAUGUS
ALLEGANY
STEUBEN
SCHUYLER
CHEMUNG
TOMPKINS
TIOGA
CAYUGA
ONONDAGA
OSWEGO
CORTLAND
BROOME
CHENANGO
MADISON
ONEIDA
JEFFERSON
LEWIS
ST. LAWRENCE
FRANKLIN
CLINTON
ESSEX
HAMILTON
HERKIMER
FULTON
MONTGOMERY
OTSEGO
DELAWARE
SCHOHARIE
SCHENECTADY
SARATOGA
WARREN
WASHINGTON
RENSSELAER
ALBANY
GREENE
COLUMBIA
ULSTER
SULLIVAN
DUTCHESS
ORANGE
PUTNAM
WESTCHESTER
ROCKLAND
BRONX
NEW YORK
QUEENS
KINGS
RICHMOND
NASSAU
SUFFOLK
LONG ISLAND SOUND
ATLANTIC OCEAN
PENNSYLVANIA
NEW JERSEY
CONNECTICUT
MASSACHUSETTS
CANADA
VERMONT

TABLE OF CONTENTS

Regional Map 4

Regional Committee Members and Consultants 6

Foreword 12

Introduction 13

Planning Overview 16

PART I

Administrative and Legislative Needs 21

Funding 27

Manpower 31

Improved Service Delivery 34

Expanded Vocational Rehabilitation Services 43

PART II

Estimates of Disability 55

Disability Recommendations 58

The Blind and Visually Handicapped 58

Auditory Speech Disabilities 66

Heart Disease, Cancer and Stroke 75

Emotionally Handicapped 81

Mental Retardation 85

Socio-Medical Handicaps 87

Arthritis 92

Respiratory Handicaps 98

Trauma and Orthopedic Handicaps 101

PART III

Planning Operations of the Regional Advisory Committee 107

Appendices 115

Appendix A - New York City Regional Interdepartmental Rehabilitation Committee (NYCRIRC) and New York City's Primary and Secondary Rehabilitation Centers 117

Appendix B - Rehabilitation Counselors 127

Appendix C - Rehabilitation Needs in Queens 134

Appendix D - Staten Island's Vocational Rehabilitation Needs 148

MEMBERSHIP OF REGION I EXECUTIVE COMMITTEE

Chairman - W. Walter Watts
Vice-Chairman - Bertram J. Black
Assistant to Chairman - E. Paul Fitz Gerald

Honorary Chairman - John V. Lindsay, Mayor of the City of New York

Borough Chairmen

Manhattan - Joseph Weber
Bronx - Robert Manheimer, M.D.*
Brooklyn -
Queens - Mrs. Henrietta Hankin
Richmond - Mrs. John K. Bash

Resource Members

Commission of the Blind and Visually Handicapped - George A. Katz
Division of Vocational Rehabilitation - Louis Salzman
Representative of Mayor of City of New York - Donald P. Conwell, M.D.
NYC Regional Interdepartmental Rehabilitation Committee - Florence M. Stattel
Federal - State Operations - Salvatore DiMichael, Ph.D.

General Studies Chairmen

Manpower - Joseph G. Benton, M.D.
Funding - Robert W. Dowling
Legislation - David Noah Fields
Research - Wilfred Haber, Ph.D.
Labor, Industry - Michael Sampson

Disability Task Group Chairmen

Blind & Visually Handicapped - Mrs. Sidney S. Pollack**
Auditory-Speech Handicaps - Edna S. Levine, Ph.D.
Heart, Cancer, Stroke - Bruce Grynbaum, M.D.
Emotionally Handicapped - Bertram W. Pepper, M.D.
Mentally Retarded - Margaret J. Giannini, M.D.
    - Nathan M. Slater
Socio-Medical Handicaps - Charles H. King
    - Jewell Phillips
Arthritis - Currier McEwen, M.D.
    - Allan M. Wolfe, M.D. (Alternate)
Respiratory Handicaps - Irving Mushlin
Trauma and Orthopedic - Marygold Nash, D.S.W.
Neurological Handicaps - Melvin D. Yahr, M.D.
Addictions - Alcoholism - Narcotics - Thomas P. Carpenter

REGIONAL ADVISORY COMMITTEE

Arthur S. Abramson, M.D., Chairman
Department of Rehabilitation Medicine
Albert Einstein College of Medicine
Bronx

Albert Agran, Director of Rehabilitation
New York State Workmen's Compensation Board
New York City

Ann Altman, Associate Consultant
Employment Service
New York State Department of Labor
New York City

Elmer E. Baker, Jr., Professor
New York University School of Education
New York City

Irving Barshop, Associate Executive Director
Federation Employment and Guidance Service
New York City

Patricia Bash, Director
Social Planning Committee
Staten Island Community Chest and Council
Staten Island

John H. Beard, Executive Director
Fountain House Foundation
New York City

Nathan Beckenstein, M.D., Director**
Brooklyn State Hospital
Brooklyn

Joseph G. Benton, Dean
College of Health Related Professions
Downstate Medical Center
Brooklyn

Bertram J. Black, Director
Mental Health Rehabilitation Services
Bronx State Hospital
Bronx

Henry Brill, M.D., Director
Pilgrim State Hospital
West Brentwood

Reverend Eugene S. Callender, Executive Director
New York Urban League
New York City

George J. Carmichael, Vice-President, Personnel
New York Telephone Company
New York City

Thomas P. Carpenter, President
National Council on Alcoholism
New York City

William G. Clancy, Associate Probation Consultant
Division of Probation
New York State Department of Correction
New York City

Donald A. Covalt, M.D., Associate Director
Institute of Rehabilitation Medicine
New York City

Reverend Thomas F. Cribben, Associate Director
Apostolate for the Deaf
Brooklyn

Frances Cronin, Superintendent
St. Joseph's School for the Deaf
New York City

Helen Cusack, Assistant Director
Visiting Nurse Service of New York
New York City

Robert C. Darling, M.D., Director
Department of Rehabilitation Medicine
College of Physicians and Surgeons
New York City

Francis J. de Bilio, Director of Rehabilitation
New York City Department of Correction
New York City

Dominick DeJohn, Administrative Director
Blind Industrial Workers Association, Inc.
Brooklyn

Oscar K. Diamond, M.D., Director
Manhattan State Hospital
New York City

Donald G. Dickson, M.D., Associate Commissioner
for New York City Affairs
New York State Department of Health
New York City

Salvatore DiMichael, Director
Institute for the Crippled and Disabled
New York City

Gordon A. DiPaolo, Faculty Member
College of Business Administration
St. John's University
Brooklyn

Vincent P. Dole, M.D., Professor
Rockefeller University Hospital
New York City

Robert W. Dowling, Chairman
City Investing Company
New York City

Max Dubrow, Executive Director
Association for Retarded Children
Training Center and Workshop
New York City

Irwin Feifer, Director
Manpower Programs, Research Laboratory
Mobilization for Youth, Inc.
New York City

David Noah Fields
Attorney at Law
New York City

E. Paul Fitz Gerald, Public Relations Consultant
New York State Department of Health
New York City

James W. Fogarty, Executive Director
Community Council of Greater New York, Inc.
New York City

S. Charles Franco, M.D., Assistant Vice-President
Consolidated Edison Company, Inc.
New York City

Max Friedman, Managing Editor
Empire State News
Empire State Association for the Deaf, Inc.
Bronx

Harold T. Fuerst, M.D., Professor
Department of Preventive Medicine
New York Medical College
New York City

William F. Gallagher, Manager
Rehabilitation and Vocational Services
New York Association for the Blind
New York City

Margaret J. Giannini, M.D., Director
Center for Mental Retardation
New York Medical College
New York City

I. Ignacy Goldberg, Professor
Department of Special Education
Teachers College, Columbia University
New York City

Jerome M. Goldsmith, Executive Director
Jewish Board of Guardians
New York City

Bruce Grynbaum, M.D., Director
Rehabilitation Medicine
Beekman Downtown Hospital
New York City

Wilfred Haber, Division Head
Division of Rehabilitation Education
New York University
New York City

Reverend Lynn L. Hageman, Director
Exodus House, Inc.
New York City

Robert Hallinan, Supervising Parole Officer
Division of Parole
Executive Department
New York City

Jack Hammond, M.D., Director
Willowbrook State School
Staten Island

Henrietta Hankin, Executive Director
Queensboro Council for Social Welfare, Inc.
Jamaica

John Harrington, Principal
School for the Deaf, Public School 158
New York City

Helen M. Harris, Executive Director
United Neighborhood Houses
New York City

Monsignor Edward D. Head, Executive Director
Catholic Charities, Archdiocese of New York
New York City

James G. Henderson, Director
Social Welfare Bureau
The Salvation Army
New York City

Maurice O. Hunt, Deputy Commissioner*
New York City Department of Social Services
New York City

George A. Katz, Senior Rehabilitation Counselor
Commission for the Blind and Visually Handicapped
New York State Department of Social Services
New York City

Florynce R. Kennedy
Attorney at Law
New York City

John J. Keppler, Executive Vice President
Federation of Protestant Welfare Agencies
New York City

Charles H. King, Director
Community Development
Albert Einstein Medical Center
Bronx

Irving F. Klein, M.D., Hospital Administrator
Seaview Hospital and Home
Staten Island

Karl Kreder, Vice President, Personnel
Metropolitan Life Insurance Company
New York City

Edna S. Levine, Professor
School of Education, New York University
New York City

Joseph H. Louchheim, Deputy Commissioner
New York State Department of Social Services
New York City

Milton Lowenthal, M.D., Director
Center for Chronic Disease
Bird S. Coler Hospital
New York City

Richard M. Lubell, Assistant Superintendent
Special Services
New York City Board of Education
Brooklyn

Donald C. Lum, Director, Employee Relations
Chas. Pfizer and Company, Inc.
New York City

Mildred McDonnell, Executive Secretary
Queens County Chapter
National Multiple Sclerosis Society
Jamaica

Currier McEwen, M.D.
New York Chapter, Arthritis Foundation
New York City

Robert H. Manheimer, M.D., Past Medical Director*
New York Arthritis Foundation
New York City

Jose Morales, Jr., Executive Director
Puerto Rican Community Development Project, Inc.
New York City

Irving Mushlin, General Director
New York Tuberculosis and Health Association
New York City

Marygold Nash, Executive Director
New York Service for Orthopedically Handicapped
New York City

Gertrude O'Connell, Coordinator
Special Services for the Deaf
Division of Employment
New York State Department of Labor
New York City

Owen Peagler, Director
New York State Office of Economic Opportunity
New York City

Lester Peddy, Executive Director
Brooklyn Bureau of Social Service
and Children's Aid Society
Brooklyn

Bertram W. Pepper, M.D., Associate Commissioner
New York State Department of Mental Hygiene
New York City

Marvin E. Perkins, M.D., Director of Psychiatry
Beth Israel Medical Center
New York City

Jewell K. Phillips, Assistant Director
Goodwill Industries of Greater New York, Inc.
New York City

Zena S. Pollack, Administrative Director**
The Jewish Guild for the Blind
New York City

Ida Rappaport, Executive Director
Association for Children with
Retarded Mental Development
New York City

Bernard F. Riess, Director
Rehabilitation Research
Post Graduate Center for Mental Health
New York City

Eleanor C. Ronnei, Administrative Director
New York League for the Hard of Hearing
New York City

Lucille Rose, Director
New York City Region, National Association for
the Advancement of Colored People
Brooklyn

Bernard Rosenberg, Director
Vocational Rehabilitation Services
Institute for the Crippled and Disabled
New York City

Julian E. Rosenthal, M.D., Associate Director
Department of Rehabilitation Medicine
New York Medical College
New York City

David G. Salten, Executive Vice President
Federation of Jewish Philanthropies of New York
New York City

Louis Salzman, District Supervisor
Division of Vocational Rehabilitation
New York State Education Department
New York City

Michael Sampson, Business Manager
Local 1-2, Utility Workers Union of America
New York City

Constantine Sedares, Assistant Commissioner
New York City Human Resources Administration
New York City

Nathan Slater, Program Coordinator
Federation of the Handicapped
New York City

John J. Sommer, Co-Director
Mental Health Rehabilitation Program
Sidney Hillman Health Center
New York City

Florence M. Stattel, Coordinator
New York City Regional
Interdepartmental Rehabilitation Committee
New York City

Samuel Sverdlik, M.D., Director
Department of Rehabilitation Medicine
St. Vincent's Hospital and Medical Center
New York City

Joseph D. Terenzio, Commissioner
New York City Department of Hospitals
New York City

Maurice Ward, President
The Joint Handicapped Council
New York City

W. Walter Watts, Senior Executive Vice President
Radio Corporation of America
New York City

Joseph Weber, Director of Agency Relations
The Greater New York Fund
New York City

Daniel Wieder, Executive Director
United Cerebral Palsy of Queens, Inc.
Jamaica

Jack F. Wilder, M.D., Director
Soundview-Throggs Neck Community
Mental Health Center
Bronx

Melvin D. Yahr, M.D., Professor of Neurology
College of Physicians and Surgeons
Columbia University
New York City

Israel Zwerling, M.D., Director
Bronx State Hospital
Bronx

CONSULTANTS

Franklin B. Amos, M.D.
Albany

Maurice Bachrach
New York City

Louis Battica
Brooklyn

Celia S. Benney
New York City

Owen Bernstein
New York City

Lucy Blair
New York City

Henry Blanchard
New York City

Gertrude Bolden
New York City

Miriam C. Brennan
New Hyde Park

John T. Connolly
New York City

Donald P. Conwell, M.D.
New York City

Madeline E. Dalton
Brooklyn

Roberta DeMar
New York City

Edward Dolan
New York City

Dorothy Doob
New York City

Lily Engler, M.D.
New York City

Thomas H. Fay, Jr.
New York City

Norman D. Fenster
New York City

Herbert Freilich, M.D.
New York City

Robert S. Goodheart, M.D.
New York City

Seymour Greenwald
Jamaica

Inez Haynes
New York City

Abraham Helfand
Freeport

Solomon Hoberman
New York City

Beatrice Joyce
New York City

Lawrence I. Kaplan, M.D.
Elmhurst

Henry D. Kavkewitz
New York City

Gerald Kissin, M.D.
Bronx

Morton S. Kleinman
New York City

Vincent dePaul Larkin, M.D.
Brooklyn

Marcia Lawrence
New York City

David D. Lehine, M.D.
Jackson Heights

Claude LeMonier
New York City

Joan P. Leonard
Elmhurst

Louis L. Levine
New York City

Patricia Livingston
New York City

Fred Lobel
New York City

Max Lupkin
New York City

Bernice McCray
New York City

John J. McElheny
New York City

Roger A. Myers
New York City

Stanley Meyers
New York City

Martha Montor
New York City

Mary S. Neal
New York City

Leonard S. Neleson
New York City

Darya L. Penn
Elmhurst

Michael Plishner
Jamaica

William J. Plunkert
New York City

Eugene Potter
New York City

Sol Prigohzy
Brooklyn

Maureen Pyne
New York City

John G. Reiners
New York City

Joan Ross
New York City

Edward Sackstein
Jackson Heights

Stanley Sadofsky
New York City

Frances Savage
Brooklyn

Frances Schuff
Bronx

Norma Scott
New York City

Boyd V. Sheets
Brooklyn

Joseph V. Shostak
Bronx

Seymour Silverberg
Jamaica

Allen Sussman
New York City

Martha L. Taylor Sarno
New York City

Harriet Tiebel
New York City

Richard C. Unger
New York City

Anita S. Vogel
New York City

Marvin Wayne
New York City

William H. Wells
New York City

Barbara Wilson
Bronx

Harold Wise, M.D.
Bronx

Allan M. Wolfe, M.D.
New York City

Emil M. Zabell, M.D.
New York City

Pearl Ziedner
Jamaica

* Resigned
** Deceased

FOREWORD

In attending Task Group meetings, in participating in many conferences with rehabilitation-minded people, and in assisting in the preparation of this Regional Report, one comes away with many impressions. Perhaps the most dominant one is the infectiousness of the concept of rehabilitation. When initiates are exposed to its principles, which continually change to broader applications, they sometimes develop the fervor of a convert.

It may be that the strength and weakness of rehabilitation lies in the absence of a priesthood. No one profession advances its cause or fights for its widespread adoption. Rather, it is a focal program that attracts many disciplines willing to marshall their skills in behalf of a disabled man or woman who, with considerable anxiety, wants to be productive.

The wonder of rehabilitation, and its attractiveness, is found in the broad array of services it makes available. The vocational rehabilitation client is given the tools he needs to become self-sustaining. He has a practical goal within the limitations he sets for himself.

But the participants in this planning process have been aware of the need to improve vocational rehabilitation services and to reach out to more and more potential service consumers. Providing the tools by which handicapped people can better help themselves is of great importance. And, to paraphrase a statement in the report, the vocational rehabilitation community is the best equipped by working philosophy and experience to provide these tools and to insure that they will be well used.

The report that follows acknowledges both the strengths and weaknesses of the public and private rehabilitation community. It suggests that the vocational rehabilitation discipline is now poised between at least three courses of action: to accept an increasingly larger responsibility that requires an integration of inter-disciplinary and inter-agency services; to examine its teachings and philosophy in light of these responsibilities; and as is suggested in the report, to view rehabilitation as a system in its own right and to program it accordingly.

Growth and accompanying change are forecast in any case.

"Major Rehabilitation Needs and Goals in New York City" points to many specific suggestions which can improve present services. It also suggests alternatives to present programs and policies and in so doing, it identifies and creates many problems which will require resolution in the future.

Controversy about the report's findings and recommendations will undoubtedly follow. And so it should.

Henry R. Marquit
Regional Planning Director

INTRODUCTION

The Dimensions of Rehabilitation

Rehabilitation has several aspects, each of which is labeled by the discipline or agency responsible for a specific range of client services. Because the title of this report deals with the broader aspects of rehabilitation, some explanation of the other dimensions is appropriate.

Rehabilitation includes medical, psychiatric, educational, social, psychological, vocational, and recreational programs which may be administered in a variety of residential or community settings, such as a general or mental hospital, rehabilitation center, educational facility, or correctional institution. It is a goal-directed process "through which a physically disabled, mentally retarded, mentally ill or socially (or vocationally) handicapped person is assisted in an organized way to develop...his maximum level of independence and economic productivity."[1]

A pattern of specific techniques, practices, responsibilities, and services has been developed in several major areas. This report deals with vocational rehabilitation directly, and also relates to medical rehabilitation. There is also an implied concern for the growing field of correctional rehabilitation. In the mental hygiene field, rehabilitation is regarded as a therapeutic modality. "The various rehabilitation therapies -- occupational, recreational and social -- help to restore a sense of usefulness and self-assurance to those who are ready to return to society."[2] It can thus be seen that Rehabilitation, viewed broadly, has many dimensions, all of which are interrelated. Each of them perceives the "client not just as a potential member of the labor force, but as a physical, psychologic, social, cultural entity -- the 'whole' man."[3] Further distinction between medical and vocational rehabilitation should be made.

Medical Rehabilitation refers specifically to the cure, treatment, and restoration of the patient suffering from an injury, disease, or mental illness. It is concerned not only with the causes of an impairment, but with the limitations the impairment imposes upon the patient and with the amelioration of symptoms to the extent possible. Restoration may involve surgery, prescription of a prosthesis or other therapeutic treatment. Medical rehabilitation is usually under the supervision of a physician when the patient is either hospitalized or seen as an out-patient. For those with chronic illness or where the condition will deteriorate, medical supervision can be protracted.

Some of the literature distinguishes between rehabilitation as a broad medical concept and as a medical speciality such as physical medicine or orthopedics. "Virtually every patient who is severely ill needs a measure of rehabilitation...which ideally starts as soon as the illness has been diagnosed and treatment has been initiated. Rehabilitation thus viewed is not a battery of special techniques but an approach to the patient in which the patient's feelings about his illness are perceived, and the social and emotional problems the patient may encounter in the process of recovery are anticipated." Physical medicine, on the other hand is a medical specialty "which uses physical energies or means to diagnose and treat diseases involving muscles, the nerves which innervates them, ligaments, tendons, and joints."[4]

Many hospitals have departments of physical medicine and rehabilitation which treat a wide variety of categorical illnesses. Throughout the state Primary and Secondary Rehabilitation Centers have been designated to offer comprehensive medical rehabilitation to patients. However, for many patients, the recovery process is a long one and this may require long hospitalization or medical supervision. Some patients, however, within a reasonable length of time may be discharged and, if indicated by the doctor, may be referred to a rehabilitation agency in the community for further evaluation and training leading to some type of appropriate employment or a sheltered workshop setting.

Vocational Rehabilitation is a process that uses the skills of many different professions and disciplines on behalf of its clients. It is concerned with "health, because of the wide range of medical services needed for those who are physically or mentally handicapped; education, because of the specialized pedagogics required to teach and retrain the handicapped; social, because of the behavioral interplay between the individual, his family, and community; vocational training, because of the need to help the disabled to acquire occupational skills adapted to his capacity and personal limitations."[1]

---

[1] Joseph Fenton and Martha Thompson, editors, New York State Programs and Services in Rehabilitation, The Governor's Council on Rehabilitation, Albany, (Rev. April 1967)

[2] Mental Illness and Its Treatment--Past and Present, U.S. Department of Health, Education and Welfare, Public Health Service, Washington, D.C. No. 1345, 1965

[3] Jean S. Felton, M.D., Dorothy C. Perkins, and Molly Lewin, A Survey of Medicine and Medical Practice for the Rehabilitation Counselor, United States Department of Health, Education and Welfare, Vocational Rehabilitation Administration, Washington, D.C. 1966

[4] Felton, Perkins and Lewin. Ibid.

The two key agencies in New York City who are responsible for providing community-based services are the Division of Vocational Rehabilitation under the State Education Department and the Commission for the Blind and Visually Handicapped under the State Department of Social Services. A full explanation of these two agencies and the way they relate to the many rehabilitation facilities is found in the General Handbook for Advisory Committee Members.[1] The specific services and eligibility criteria are also included.

It must be noted, however, that vocational rehabilitation is no longer a service that is exclusively for those with physical and mental handicaps. Legislation (PL 90-391) extends services to those with social disabilities who have vocational handicaps to employment. The historical base--services for the physically and mentally disabled--is the foundation upon which expanded client services are to be offered. Medical factors need not be the dominant eligibility criteria, particularly for the 'disadvantaged'. Yet for the client with physical and mental handicaps, the legislation and state policy mandate quality services with considerable dependence on the medical community for evaluative, diagnostic and restorative services. In practice, and more significantly in future programming mandated by the Vocational Rehabilitation Act Amendments of 1968, vocational rehabilitation has a broad scope. It is seen as a delivery system with close ties to medicine, social welfare, and manpower programs, education, and vocational training.

The expansion of eligibility criteria to younger and older persons, the inclusion of special problem groups such as alcoholics, criminal offenders, drug addicts, and the culturally disadvantaged imposes vastly different service imperatives than has been the case in the past. The requirement for developing projects with industry and developing new career programs that would enable public and private agencies to recruit and train handicapped individuals to provide them with new career opportunities in the fields of rehabilitation, health, welfare, public safety...and other appropriate public service employment, and the implementation of the State Vocational Evaluation and Work Adjustment Program, are examples of new dimensions of the traditional program. The qualifier, "vocational," becomes a misnomer. Rehabilitation, in its broadest sense, is what has emerged from the past.

The Regional Report attempts to focus more immediately on what is now the vocational rehabilitation field and it advocates a rehabilitation service continuum that depends greatly on other major service providers. It suggests strong coordinative and integrative roles in closely related rehabilitation programs. It also suggests on a comprehensive scale the major rehabilitation needs and goals in New York City.

Scope of Report The Table of Contents gives an overview of the subjects included. The framework is provided by the Task Group Reports which have been previously submitted to the Executive Committee. Task Group Reports have identified a wide range of problems and concerns. The purpose of this report is to integrate these concerns into major areas so that appropriate recommendations could be offered. Since the report's scope is a broad one, no attempt has been made to list each Task Group recommendation either in the Regional Recommendations or in the Task Group summaries. The full list of recommendations are to be found in each of the Task Group Reports. The most significant Task Group recommendations are included in Part II.

The tenor of this report is to stress that vocational rehabilitation is not an isolated service, nor is it parochial. Rather, it is pervasive and extends to other disciplines and other major systems. How to build on this inter-relationship in order to serve more individuals effectively is also dealt with in the pages that follow.

Organization of Report Part I contains findings and recommendations of a general nature which have been developed from the Task Force material. Accompanying each recommendation, or preceding it, justifications are offered. These are necessarily evaluative and critical and where additional material was pertinent, it was included. Part II contains the major recommendations and summaries of the individual Task Group Reports. Here too, the summaries are critical.

Part III contains appendices. It includes a review by staff of New York City's Primary and Secondary Rehabilitation Centers. Because this is a staff report, no recommendations are offered. The Regional Executive Committee discussed the review and directed its inclusion here. Another topic is a position paper on rehabilitation counselors prepared for the Manpower Task Group by Dr. Marvin R. Wayne. Appropriate recommendations have been suggested by Dr. Wayne. Also appended are the report and recommendations of the Task Group for Queens County. Although it has not been analyzed or referred to in the text, it will be found that the Queens Committee Report supplements and supports many of the recommendations in Parts I and II. A memorandum from the Chairman of the Task Group for Staten Island lists borough trends and needs.

Methodology In order to obtain uniformity in coverage for all Task Groups, a questionnaire was developed which was designed to be broad, but at the same time focus on: a) those with a particular disability who could benefit from vocational rehabilitation, b) the extent of New York State Division of Vocational Rehabilitation service, c) identification of other voluntary and public agencies providing vocational rehabilitation and suggestions for expansion, modification or elimination of these services, d) identification of the most crucial gaps in programs and resources to provide for unmet needs, and finally, e) listing of priorities for implementation.

---

[1] General Handbook for Advisory Committee Members, Office of Statewide Planning for Vocational Rehabilitation Services, The State Education Department, Albany, New York, 1967

The procedure used for organizing Part I was to identify the major issues presented in Task Group reports, minutes, and position papers, and discuss each item and list appropriate recommendations.

For Part II, the disability summaries were reduced to three major headings: 1) Incidence and Prevalence, 2) Extent of Services, 3) Recommendations. In order to handle the data more easily, items b) through d) of the questionnaire were combined in "Extent of Services." Included in Part II are the planning operations of the Regional Advisory Committee. It was prepared by Regional Staff.

Recommendations are usually concise statements indicating the agency or groups responsible for implementing the recommendation. Where this has not been done in the Task Group Reports, they have been inserted in the summaries. Many recommendations are complicated and have many implications. Within the time limitations imposed there was not sufficient attention given to exploring these implications, or to obvious technical details. This will be left to an on-going planning group and to the administrative echelon of the rehabilitation agencies.

One of three possible priorities - Urgent, Essential, Desirable - was assigned to each recommendation. The recommendations felt to have highest priority were labelled Urgent, those with lowest priority Desirable.

In an attempt to indicate when recommendations ought to be implemented, the following key was used:

Interim: Implementation is to be achieved before June, 1972.
Short Term: Implementation is to be achieved between June, 1972 and June, 1975.
Long Range: Implementation is to be achieved after June, 1975.

Textual references to "the State Rehabilitation Agencies" mean the Commission for the Blind and Visually Handicapped, Rehabilitation Counseling Section of the New York State Department of Social Services, and the Division of Vocational Rehabilitation of the New York State Education Department. The term "rehabilitation community" is generic and refers to those agencies and practitioners who perform rehabilitation services of any kind. Cross references to other recommendations are made by using the first letter of the section in Part II where the recommendation appears. The number of the recommendation also appears.

A PLANNING OVERVIEW

Central to any planning effort is the need for knowledge about basic data, the population in need of a particular kind of service, the numbers involved, the resources available to meet current need and the process of service delivery and costs.

Task Group members gathering such data as was available have identified in their reports problems in service delivery, and included both the gaps and needs which require attention. Some Task Group Reports have charged the vocational rehabilitation community with responsibility for the implementation of their recommendations.

Such a wide inventory of service needs has been presented that it becomes virtually impossible for one government agency, or specifically, the vocational rehabilitation agency, to fill these needs unless there were substantially more personnel, funds and resources. However, some Task Group Reports stress that many agencies provide services to the handicapped and disabled, and that major units of government provide either funding or direct services. The reports do not make clear whether full responsibility to fill all the gaps and meet all the needs should be within the vocational rehabilitation community, or whether the other major service deliverers should do so. For example, a report prepared for the Education sub-committee proposed that the Division of Vocational Rehabilitation should provide psychological evaluations for school aged children because the New York City Board of Education's Bureau of Child Guidance was unable to do so.

In addition, all Task Group Reports have recognized that vocational rehabilitation is part of a broader spectrum of services. Some reports seemed to charge the vocational rehabilitation agency with the responsibility for improving health services in the community. The Trauma Task Force Report cited the need for "more extensive physical medicine, orthopedic, neurological, and amputee clinics in each neighborhood," while diagnostic and evaluation centers in hospital facilities were advocated in the Arthritis Task Force Report to "give comprehensive evaluation and a detailed program of care of each patient." Who was to provide funding, staffing and administrative control was not specified, nor was shared responsibility delineated.

There are other problems for vocational rehabilitation planning.

1. Some Task Groups noted the expanded concept of disability that includes social factors as contributing towards an individuals handicap. Others stressed the need to improve the quality of services for the severely handicapped. In the rehabilitation of those with primarily medical disability, many gaps in service delivery have been identified. The Congressional committee reporting on recent amendments to the Vocational Rehabilitation Act, had this to say, "...the committee believes that additional emphasis should be placed on the vocational rehabilitation of the severely handicapped rather than those individuals who can readily be placed in employment."[1] If this emphasis is accepted, will not this influence our planning priorities?

2. Services for the chronically disabled were also the concern of several reports. What services should the vocational rehabilitation agency provide for those people who have either a progressively deteriorating medical condition, or who are so disabled that they cannot find a place in competitive society?

3. Related considerations are the extended long-term rehabilitation workshop, and the need to provide realistic follow-up services to those who have been rehabilitated. Present follow-up by the Division of Vocational Rehabilitation is obligatory for 30 days. In practice this may be prolonged for a few months, but an appreciably longer follow-up period has been suggested.

4. Both services to children and programs for the aged are now the concern of the vocational rehavilitation movement. Since 1965, when Congress removed age restrictions on eligibility for vocational rehabilitation services, there has been virtually no programming for these two groups. There are isolated instances of service acceptance or services connected with research or demonstration, but both young and old are excluded from the vocational rehabilitation process. It is not that the Division of Vocational Rehabilitation was unwilling to serve them; it has not the resources of money and staff to begin services. Thus, for older people the phrase "a reasonable expectation that vocational rehabilitation services may render the individual fit to engage in a gainful occupation," is exclusionary. For the young person especially, another criterion is used, "vocational proximity," which tends to rule out early involvement in rehabilitation. By extending services to the younger and older person, what specifically can the vocational rehabilitation program offer to a 7-year old child or a 70-year old man? Some reports suggest answers.

---

[1] Report to accompany HR 16819, Vocational Rehabilitation Amendments of 1968, 90th Congress, 2nd Session, Senate Calendar No. 1288, Report No. 1309, June 21, 1968, p.8

5. The planning tasks are complicated because of the pressure to render services to special population groups within the existing framework of services. This includes those with prison records, juvenile offenders, alcoholics and drug addicts.

The clear implication for vocational rehabilitation planning is that extensive study of related systems, cost sharing and interagency relationships is needed. While there is some preparation of the community and the rehabilitation field for the need to change service patterns, much remains to be accomplished. The vocational rehabilitation movement is by no means a parochial one although current trends are of sufficient challenge to require even broader viewpoints and approaches.

By striving for a unification of related services and service deliverers, and by recommending alternative approaches which would enhance the rehabilitation process within recognized rehabilitation agencies, forward movement toward programming a major system can be achieved. Interpretation of much of the data can lead to the conclusion that rehabilitation should be and ought to be a total system in its own right; that rehabilitation, or habilitation is a desirable goal of many institutionalized systems that are ostensibly devoted to encouraging individuals under care toward greater independence.

PART I

ADMINISTRATIVE AND LEGISLATIVE NEEDS

The concept of disability has been broadened, not only by the findings of the Task Group Reports, but by federal legislation. The inclusion of social, cultural, educational and environmental elements with the traditional view of "health disability" creates a formidable task in the structuring of services.

The barriers of fragmentation and duplication of services on the part of governmental and private agencies will need to be breached. Professional rigidities, as the reports note, will have to give way to more flexible and cooperative attitudes. Outmoded forms of practice in providing service will have to yield to more common-sense and efficient techniques. New York State Commissioner of Education, James E. Allen, in a recent speech in Boston, delivered a challenge:

> "There must be a willingness to innovate, to discard tradition where necessary, to be bold and daring, to consider new patterns of organization, to enter into new relationships, and to move with vision and imagination."

The clear mandate of the Regional Advisory Committee has been to discuss and survey the need for change and at the same time to highlight that which requires change. It is recognized that tampering with tradition and suggesting "new patterns of organization" will not only require vision and imagination, but persuasion.

Targets

Analysis of the Task Group Reports seems to indicate that the first target for change is within the New York State Division of Vocational Rehabilitation and the voluntary agencies relating to it so that the service process can be improved. A second target for change is to integrate, or bring more closely together, the profusion of service deliverers.

A third target is to press for additional legislation, if necessary, and the promulgation of revised administrative policies to conform with the recommendations that follow. For example, the permissive legislation of PL 90-391 enables the state rehabilitation agency to "...pool its funds with the funds of another agency to develop a program to serve clients for whom both agencies have some responsibility."[1] Implementation is discussed in the section dealing with Funding.

A fourth target for exploration is the determination of whether or not the New York City Region might be able to develop a better set of service patterns for clients needing rehabilitation if there was direct local administrative and operational responsibility. Supervision would be under the state rehabilitation agency, but there would be a wider range of options which a local body could implement without the restrictions imposed by the needs of upstate counties.

Legislative and Administrative Concepts

So complex an area as vocational rehabilitation presents a formidable set of administrative problems. This is suggested by a description of the structural and functional components of the field:

> Functionally, rehabilitation encompasses a number of specialized programs to give handicapped men and women the special services they need to compete more equally and live more productively.[2]
>
> Structurally, these processes place rehabilitation within several disciplines or groupings: health, because of the wide range of medical services needed for those who are physically and mentally handicapped; education, because of the specialized pedagogics required to teach and retrain the handicapped; social, because of the behavorial interplay between the individual, his family, and the community; vocational training, because of the need to help the disabled to acquire occupational skills adapted to his capacity and personal limitations. Effective vocational rehabilitation encompasses all these elements and is part of a comprehensive program.[3]

In New York State the Division of Vocational Rehabilitation provides any one or a combination of services from a variety of professional agencies and a variety of professional disciplines. More effective coordination has been sought between major administrative units in government since it was recognized that physically and mentally handicapped people are at one time or another recipients of health services, public assistance, Workman's Compensation, employment services, mental hygiene, and because some individuals are known to corrections, parole and probation units.

---

[1] Op. cit. (Report No. 1309) p. 6.

[2] Mary E. Switzer, "Vocational Rehabilitation in the United States," International Labour Review, LXXVII: No. 3, March, 1968

[3] General Handbook for Advisory Committee Members, Office of Statewide Planning for Vocational Rehabilitation Services, Albany, New York, June, 1967, Appendix A., p. A-2

Responsibility for the coordination of rehabilitation services among the state departments was vested in the Interdepartmental Health and Hospital Council which was created by the Governor's Executive Order in 1960. The extent of involvement of state agencies in rehabilitation is detailed in a recent publication of the Governor's Council on Rehabilitation which lists eight major State Departments..."with varied responsibilities for a gamut of rehabilitation services..." It identified at least thirty other divisions and bureaus involved "in rehabilitation programs in varying degrees."[1]

Despite the heavy reliance placed on joint funding and program ventures by current legislation, some caution toward over-reliance on coordinating councils was expressed by Basil Mott.[2] He deemed the Interdepartmental Health and Hospital Council to have limited ability to get meaningful interdepartmental coordination underway. Department Commissioners were too reluctant to give up any of their prerogatives, and in the absence of hierarchal leadership the goals of the council were not really fulfilled. A similar view is shared by participants in a planning conference held at Brandeis University in 1966. Attempts at interdepartmental coordination within several states were discussed, and for the most part, they did not work.[3]

Some Task Group Reports such as that of Heart, Cancer and Stroke, viewed this administrative profusion with candor. "The greatest improvement in vocational rehabilitation services could be obtained by a larger, more efficient agency which might be independent or placed under some other part of the government...which will be expected to absorb some governmental units which also provide rehabilitation services." Further study of a centralized rehabilitation agency was suggested by the following Task Groups: Respiratory Handicaps, Emotionally Handicapped, and the Auditory-Speech Category. The Task Group for the Blind and Visually Handicapped calls for a "review of the administrative procedures between public and voluntary agencies...Planned central responsibility for serving clients should be clearly established with the elimination of the duality of roles in following the clients progress."

While the most dramatic and sweeping legislative or organizational change would be tied to a major reorganization of State agencies or the creation of an independent rehabilitation agency, accomplishing such a result is difficult. A State Department of Rehabilitation would require a constitutional amendment because of the ceiling on the number of departments authorized by the State Constitution. Reorganization of state agencies is not easy to achieve for obvious reasons. It is likely that some pressures for such a change would have to be maintained over a considerable period of time.

Administrative Unification

1a THERE SHOULD BE ESTABLISHED ON A STATE LEVEL AN INDEPENDENT OFFICE OF REHABILITATION OR A DEPARTMENT OF REHABILITATION.

Priority: Urgent — Implementation Schedule: Interim

b THE DIVISION OF VOCATIONAL REHABILITATION AND THE STATE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED SHOULD DETERMINE THE FEASIBILITY OF HAVING ONE AGENCY RESPONSIBLE FOR PROVIDING SERVICES FOR BOTH THE BLIND AND THE VISUALLY HANDICAPPED.

Priority: Urgent — Implementation Schedule: Interim

The Task Group for the Blind and Visually Impaired recommended the transfer of services for the visually impaired, presently provided by the Division of Vocational Rehabilitation, to the Commission for the Blind. There is a logic to unifying services to all those with visual impairments, whether legally blind or not.

c IN VIEW OF THE PROVISION OF PL 90-391 AND OTHER APPLICABLE FEDERAL LEGISLATION, REPRESENTATIVES OF APPROPRIATE STATE AND LOCAL GOVERNMENT UNITS SHOULD DETERMINE WHETHER OR NOT THE CITY OF NEW YORK SHOULD ESTABLISH A DEPARTMENT OF REHABILITATION.

Priority: Urgent — Implementation Schedule: Interim

---

[1] Joseph Fenton, and Martha M. Thompson, Editors; New York State Programs and Services in Rehabilitation, The Governor's Council on Rehabilitation, Albany, New York. Revised April, 1967

[2] Basil J.F. Mott, "How a Coordinating Council Operates", New York, Unpublished doctoral dissertation, December, 1966

[3] David G. French, ed., Planning Responsibilities of State Departments of Public Welfare, Conference Precedings, Brandeis University, Waltham, Mass., American Public Welfare Association, Chicago, 1967, pp. 48-49, 54-55

The implication of this recommendation is that it could be an alternative to an independent state rehabilitation agency. It would be desirable, however, to have an independent state agency in any case. Some informed members of the rehabilitation community have suggested the possible role of the City of New York in creating effective links between health, social services, mental health, mental retardation, and school systems with the vocational rehabilitation structure. A city-wide rehabilitation service could be achieved by the waiver of state-wideness provisions in the Federal Vocational Rehabilitation Act. This would enable local governments to establish vocational rehabilitation services within their own jurisdictions, but with the approval of the State Rehabilitation agency it would remain under that agency's supervision. (Refer to PL 90-391, Section 5. (a)(1)(A) and the Federal Register, Vol. 31, No. 9, Section 401.8, January 14, 1966)

Administrative Procedures

The following three recommendations are interrelated and are given high priority, but because of the need to work out complex details, short term and long range implementation goals are suggested. The goal is to identify clients who have been accurately diagnosed in terms that are appropriate to and significant in the rehabilitation process so that they can be brought into the rehabilitation referral system with the exchange of uniformly kept records. A sophisticated referral system, using electronic data processing, can be programmed to scan facility availability, determine appropriate services to match an individual's disability, and show whether or not there is a place for him.

Several problems will require further planning. Initially, rehabilitation agencies should be phased into the process, and gradually other related organizations could be included. Another major issue is that of confidentiality and the right of the individual to privacy. A central registry of the disabled may well violate these rights. Those requesting services, however, can be initially included in a registry and proper safeguards can be set. To be weighed with these problems are the increased benefits to clients needing services and the administrative flexibility which accurate and timely data yields.

The key, of course, if in the use of modern computer techniques that can be programmed to obtain a variety of statistical and planning information that can aid in the evaluation of services, facilitate supervision, detect trends and give reliable information on a continuous basis.

2 AN ORDERLY, COMPREHENSIVE REFERRAL SYSTEM SHOULD BE ESTABLISHED BY THE STATE REHABILITATION AGENCIES, HOSPITALS, REHABILITATION AGENCIES, AND OTHER PROVIDING SERVICES TO THE DISABLED.

Priority: Urgent **Implementation Schedule: Short Term**

In striving for continuity of care, from a hospital or other facility, an effective referral system is needed. This, as with the recommendations to follow, could be built into a computer system programmed for uniform disability reporting system and uniform record keeping.

There are many uses of such a system that apply both to the rehabilitation facilities and the Division of Vocational Rehabilitation. Before referrals are made information about agency services, resources and openings are needed. The Heart Disease, Cancer and Stroke Report recommends the need for an inventory or rehabilitation agencies. It also recommends making referrals available to patients or clients, doctors, and relatives, and suggests that a system is needed which provides centralized information on facility availability, service programs and program openings. A similar recommendation is made that suggests the Division of Vocational Rehabilitation give financial support to a client information center.

3 FURTHER STUDY IS REQUIRED BY THE STATE REHABILITATION AGENCIES AS TO THE FEASIBILITY OF MAINTAINING A DISABILITY REGISTER.

Priority: Desirable **Implementation Schedule: Long Range**

Several Task Groups cite the need for an accurate register of the disabled. Currently there is a Register for the Blind. The Task Group Report for the Blind recommends that such a register be computer programmed to allow for systematic follow-up and more effective case-finding. Also recommended is a correct population count. The Auditory-Speech Report makes similar recommendations. The Mental Retardation Report cites the lack of a central registry, and the need to have early case-finding for retardates.

4a THE STATE REHABILITATION AGENCIES SHOULD SECURE FINANCING TO UNDERTAKE THE DEVELOPMENT OF A UNIFORM NOMENCLATURE OF DISABLING CONDITIONS. ALTERNATIVE CONSIDERATION SHOULD BE GIVEN TO THE USE OF SOME MODIFICATION OF THE REHABILITATION CODES.

Priority: Urgent Implementation Schedule: Short Term

b THE STATE REHABILITATION AGENCIES SHOULD ESTABLISH A CENTRAL REGIONAL SYSTEM OF RECORD KEEPING AMONG REHABILITATION FACILITIES OR THOSE MAKING REFERRALS WITHIN THE REHABILITATION COMMUNITY. SUCH A SYSTEM WOULD PROVIDE FOR THE ACCUMULATION AND EXCHANGE OF INFORMATION AMONG PARTICIPATING AGENCIES.

Priority: Urgent Implementation Schedule: Short Term

There was considerable difficulty encountered by many of the Task Groups that related to terminology, and the excessive reliance placed upon national or local health surveys which depend on the subject's self-evaluation.

> "The terminology used to describe disability is frequently inconsistent, and considerable confusion exists about concepts, criteria, and operational definitions. Different terms are used to designate similar aspects of disability, and the same terms are sometimes used to designate different aspects and levels of limitation."[1]

This reference to Haber's article was made in the Socio-Medical Report, and similar objections to inadequate nosological or reporting systems were made in other reports. The lack of specificity left much to be desired, and a note was made that planners should have more reliable data available. The Hard of Hearing Task Group recommended, "a comprehensive and uniform system of terminology, record keeping and data reporting that is designed for computer analysis."

Many applications are possible with an integrated system of nomenclature and record keeping. The Heart Disease, Cancer and Stroke Report urges the development of appropriate indices of disability that would help determine for each category of disability those who could benefit from vocational rehabilitation services.

5 THE STATE REHABILITATION AGENCIES IN CONSULTATION WITH REPRESENTATIVE MEMBERS OF THE REHABILITATION COMMUNITY SHOULD ESTABLISH STANDARDS FOR REHABILITATION FACILITIES. IN ORDER TO MEET THESE STANDARDS, AGENCIES SHOULD BE GIVEN FINANCIAL AND TECHNICAL SUPPORT. A TIME LIMITATION FOR COMPLIANCE TO STANDARDS SHOULD BE SET.

Priority: Urgent Implementation Schedule: Interim

6 THE STATE REHABILITATION AGENCIES SHOULD FORTHWITH ESTABLISH ACCREDITATION STANDARDS THAT INCLUDE BOTH PROGRAM CONTENT AND PHYSICAL PLANT FOR REHABILITATION FACILITIES.

Priority: Urgent Implementation Schedule: Interim.

While these recommendations are similar, there are differences. The accredited agency would be permitted to employ certified personnel enabled to write rehabilitation plans with the client (See R-7a). They would give a range of comprehensive services and programs directly related to the state vocational rehabilitation agencies. Those rehabilitation facilities that offer segments, or only very specialized services, would not qualify for accreditation, but the content of their services would conform to standards.

There have been a number of standard-setting bodies both on national and statewide levels, but as yet, conformance to their criteria is largely optional. These recommendations would make compliance to standards or meeting accreditation requirements mandatory. Because of the financial incentives involved and the anticipated delegation of responsibility for the development of programs and services, including the writing of rehabilitation plans with clients, stronger safeguards are indicated.

By setting accreditation standards some of the disparity in agency services would be eliminated. This would encourage comprehensive programs or specialized services in order to assure quality services. Program standards should be written and provide for physical, social, emotional, and vocational rehabilitation. Accredited agencies, complying to standards would aid in eliminating "staff shortages in the health professions, service delays and administrative duplication and fragmentation may be reduced." However, in order to help agencies meet standards, the State Rehabilitation Agencies will have to give needed financial assistance as well as technical supports. In addition, some consideration will have to be given to the needs of those agencies who do not choose to comply to standards.

---

[1] Lawrence D. Haber, "Identifying the Disabled: Concepts and Methods in the Measurement of Disability," Social Security Bulletin, United States Department of Health, Education and Welfare, December, 1967

In setting a time limit for agency adoption of promulgated standards, it will be necessary to determine whether this should be accomplished on a voluntary or other basis.

7a THE STATE REHABILITATION AGENCIES SHOULD UNDERTAKE THE CERTIFICATION OF ALL VOCATIONAL REHABILITATION COUNSELORS AND PERMIT THEM TO WRITE REHABILITATION PLANS WITH CLIENTS, PROVIDED THE CERTIFIED WORKER IS EMPLOYED BY AN ACCREDITED AGENCY. APPROPRIATE LEGISLATION SHOULD BE INTRODUCED BY THE STATE EDUCATION DEPARTMENT AND PROVISIONS SHALL BE MADE FOR AGENCY ACCOUNTABILITY AND EVIDENCE OF WORK PERFORMED.

Priority: Urgent Implementation Schedule: Interim

Certification would enable trained workers employed by accredited agencies, including any hospital that meets accreditation standards, to assume responsibility for establishing eligibility for service, and if indicated, follow through with any services that are necessary. Supervision of operations would be by the State Rehabilitation Agencies. Division of Vocational Rehabilitation intake problems would be lessened and problems occasioned by the trend to longer in-service client involvement would be shared with participating agencies. In implementing this recommendation, procedures should be developed that provide for agency accountability as well as evidence of work performed.

b THE STATE REHABILITATION AGENCIES SHOULD FORTHWITH ADOPT A POLICY OF PERMITTING PERSONNEL TO ESTABLISH PRESUMPTIVE ELIGIBILITY FOR VOCATIONAL REHABILITATION SERVICES.

Priority: Urgent Implementation Schedule: Interim

As indicated in the Socio-Medical Report, presumptive eligibility is applicable where:

a. there is objective evidence of visible physical disability;
b. the non-medical referral source indicates the referral is based on present physical or emotional disability and that evidence to establish this is available in their files;
c. the client presents a detailed history to the counselor establishing a high probability of disability based on current treatment or medication.

This concept has been used successfully in California and can be adapted to New York State.

Public Information and Education

Without exception, each Task Group Report was concerned with the need for channels of communication among rehabilitation agencies, the public, health practitioners, and the academic world. The need to inform greater numbers of potential referrals about vocational rehabilitation services and to develop the concept of "outreach" to potential clients is one that can be met.

The role of an information and education program would be not only making attempts to reach the target groups mentioned so that they can be informed about rehabilitation services, but it would include intra-professional sharing of knowledge and interpretation of research or pertinent literature for its applicability to the rehabilitation community. A public information and education program is actually an administrative tool. It is not sufficient to develop new services for the rehabilitation of the disabled and expect that these services will be immediately utilized. A deliberate effort must be made to identify the target groups: the client, the professionals, other agencies, and other related disciplines. Further, results of program operations should be more widely known. Effective communication at all staff levels is a vital need.

Other functions are to educate the public on the positive work skills of the handicapped; to inform industry and labor about the benefits accruing to society when the disabled are employed; to stimulate recruitment to the counseling profession; and to promote wider acceptance of the concepts of rehabilitation among professional groups. Negative attitudes toward the Division of Vocational Rehabilitation can be dispelled by a concerted effort that informs consistently, positively, and honestly.

During one Task Group meeting, a statement was made that many agencies do not have truly effective public information programs because demand for services would then increase. Indeed, several members of the Regional Advisory Committee were uninformed about the vocational rehabilitation process.

> "This lack of awareness is especially disturbing when it is encountered among professional personnel. We were shocked to learn that the typical medical practitioner...has very little understanding of the scope, function, and resources of the public program...in rehabilitation."[1]

From the same source, the National Citizens Advisory Committee on Vocational Rehabilitation, comes this statement:

> "The vocational rehabilitation program, so far, has not even had the distinction of becoming controversial. We feel that in this time of social crisis and upheaval, rehabilitation should become controversial. Its successes and shortcomings should enter the public forum for debate and speculation. Its concepts, practices, and philosophies should be discussed, argued over, and refined so that they may be even more validly related to life in 20th century America."

8 THE STATE REHABILITATION AGENCIES SHOULD FORTHWITH ESTABLISH A PUBLIC INFORMATION AND EDUCATION BUREAU WITH ADEQUATE STAFF AND BUDGET THAT WILL FUNCTION ON A REGIONAL BASIS.

Priority: Urgent Implementation Schedule: Interim

Permanent Planning With The Community

Recent amendments to the Vocational Rehabilitation Act (PL 90-391, Section 5, (2)(13)) provide for continuing statewide studies of the needs of the handicapped individuals and how these may be most effectively met. The majority of the Task Group Reports urge continued planning. The consensus is that generalized planning as an on-going project with the participation of voluntary agencies is needed. Another report recommends "regional planning to eliminate gaps and duplication of voluntary agency services" with the participation of governmental and private agency groups.

As part of the federal guidelines for the inclusion of data in this report, the Regional Advisory Committee is obliged to make recommendations that will provide for periodic review of the entire statewide plan, including a timetable and structure and the designation of an advisory group; and continued program planning, including interagency involvement, staffing requirements, advisory groups to be retained, and roles to be performed.

9a ONE YEAR AFTER THE FINAL REGIONAL AND STATE REPORTS HAVE BEEN COMPLETED THEY SHOULD BE REVIEWED BY A REPRESENTATIVE GROUP OF THOSE PARTICIPATING IN THIS PLANNING EFFORT. IN THE REVIEW OF THE REGIONAL REPORT, THE REGIONAL CHAIRMAN AND VICE-CHAIRMAN SHOULD BE MEMBERS OF THE REVIEW GROUP.

Priority: Urgent Implementation Schedule: Interim

b THE STATE REHABILITATION AGENCIES SHOULD JOINTLY ESTABLISH AN ADEQUATELY STAFFED BUREAU OF PLANNING TO FUNCTION ON A REGIONAL BASIS. COMMUNITY INVOLVEMENT IN SUCH PLANNING SHOULD BE ASSURED BY THE APPOINTMENT OF A PANEL OR AN ADVISORY COMMITTEE OF COMMUNITY REPRESENTATIVES IN EACH REGION.

Priority: Urgent Implementation Schedule: Interim

Where there are existing planning or coordinating groups serving an area, representatives of such groups should be included on the panel. The panel will have the following responsibilities:

- Fix priorities for vocational rehabilitation services;
- Assist in on-going planning;
- Periodically review, with their regional counterparts,

---

[1] Report of the National Citizens Advisory Committee on Vocational Rehabilitation, Washington, D.C., June 26, 1968, p. 12

regional and statewide problems and advise the state rehabilitation agencies on matters of concern;

- Initiate studies or proposals of the needs of handicapped individuals and how these needs may be most effectively met.

In Regional Executive Committee discussions it was emphasized that there should be a planning unit within the State Rehabilitation Agencies charged with the responsibility for on-going planning on a regional basis. Equally important was the need to establish a regional advisory committee to assure community involvement in meeting future needs.

Several possibilities exist for an advisory committee structure, but Recommendation 9b is designed to be broad in order to take advantage of existing planning and coordinating groups. An effective advisory committee requires that it play a strong role and that it be furnished with an adequate secretariat directly responsible to the advisory committee.

In the New York City Area there are three important groups who have been active in the field of rehabilitation. These are the Community Council Rehabilitation Committee, Community Council of Greater New York; the Metropolitan New York Chapter of the National Rehabilitation Association; and the New York City Regional Interdepartmental Rehabilitation Committee. The first two organizations have memberships composed of individuals and agencies. New York City Regional Interdepartmental Rehabilitation Committee's fourteen members are employees of city and state governmental units concerned with rehabilitation. These groups have expressed interest in participating in on-going planning. These and other groups and individuals can be involved in obtaining a representative cross-section of the rehabilitation community to engage in future planning.

One suggestion for the structuring of an advisory committee called for a panel of from three to five influential and independent people who would relate to a larger, representative body and to regional counterparts in other areas of New York State. On the other hand, it was suggested that the advisory committee be composed of persons actively engaged in this planning effort. The flexibility of the recommendations as stated above, can allow for these or other possibilities.

FUNDING

Trends in Federal Funding

Both optimism and pessimism confront the rehabilitation community's financial outlook. All the lead indicators point to greatly increased government supports for services, but with augmented financing will come a charge to serve larger population groups and to develop more effective service patterns.

Startling as it may seem, by 1978 vocational rehabilitation spending in New York City will probably reach $100,000,000 annually. Should the trend in upward congressional appropriations for the vocational rehabilitation program continue, within ten years it should exceed $2 billion, and New York State's share would be $200,000,000. The basis for such optimism is found in the amounts of money authorized to be appropriated under the Vocational Rehabilitation Act Amendments of 1965 and 1968. From 1967 to 1971, authorized appropriations have more than doubled. (Table II). An important aspect of this trend has been the continual assumption by the federal government of larger shares in the matching formulas. Under the recent amendments, the federal share was increased from 75% to 80%. The states' share was lowered from 25% to 20%.

With each increase in funding, however, the legislation broadened the concept of disability and made significantly more people eligible for services. As has been described above, the socially disabled are included within the rehabilitation umbrella, albeit in a limited way. The Vocational Evaluation and Work Adjustment Program (Section 15) is almost exclusively for the disadvantaged: $50,000,000 was authorized in fiscal 1969 and by 1971 this will reach $100,000,000.

Paradoxically, but not surprisingly, federal allotments have not been released as yet, nor have the federal guidelines been released that will elaborate on the administrative implementation of Section 15. While PL 90-391 provides that each state submit evaluation and work adjustment plans, the absence of funds and the likelihood of federal approval for funding of individual work evaluation and work adjustment centers on a project basis will undoubtedly impede execution of the program at local levels. Furthermore, the allocation for New York City probably will not be sufficient to meet total needs. (The potential of Section 15 is important and it is discussed in the section dealing with Neighborhood Service Centers.) The pessimism expressed in some of the Task Group Reports is merited. The present lack of funds for the establishment of services and needed rehabilitation facilities is a sharp contrast to future potential. If public funds are not made available, expansion of services will not be possible.

TABLE II

FEDERAL FUNDING UNDER THE VOCATIONAL REHABILITATION ACT
(millions of dollars)
1966 - 1971

TYPE OF GRANT	1966	1967	1968	1969	1970	1971
Base Programs (Section 2)	$300	$350	$400	$500	$600	$700
Special Projects (Section 4)	80	104	117	80	115	140
Innovations, etc. (Section 3)	5	7	9	3.2	6	10
Rehabilitation Facilities Construction (Section 12)	1.5	7	9	10	20	30
Rehabilitation Facility Improvements (Section 13)	1.5	9	14	10	20	30
Vocational Evaluation and Work Adjustment (Section 15)	-	-	-	50	75	100
TOTALS*	$388.0	$477.0	$539.0	$653.2	$836.0	$1,010.0

*These are authorized appropriations under the Vocational Rehabilitation Amendments of 1965 and 1968 (PL 89-333 and PL 90-391) under a system of federal-state matching formulas. Between 1966 and 1968 the federal share under most of the matching formulas was 75% and the states' share 25%. With the 1968 Amendments the federal share was increased to 80% and the states' share decreased to 20%. Section 15, however, puts the federal share at 90%.

TABLE III

ACTUAL EXPENDITURES, FY 1966, 1967

Year	TOTAL FUNDS	FEDERAL	STATE & LOCAL
1966	$213,638,600	$144,629,252	$69,009,348
1967	303,845,732	225,268,026	78,557,706

Source: Report of the National Citizens Advisory Committee on Vocational Rehabilitation, Washington, D.C., June 26, 1968.

Prepared by New York City Regional Office, Office of Planning for Statewide Vocational Rehabilitation Services, New York State Education Department.

Another avenue was explored by one Task Group that recommended financial incentives in order to enable hospital rehabilitation units to meet accreditation standards. It placed funding needs along with other deficiencies in order to plea for a more systematized approach to service delivery. The Heart, Cancer and Stroke Task Group asked

> "...whether the demand for vocational rehabilitation services can be supplied by the simple addition of more funds to pay for more services and more staff. This might be advisable were the result to be other than to maintain the status quo at higher levels of cost and staff time. A review of the system is indicated. Staff shortages in the health professions, tax-

payer resistance to increased costs, administrative duplication and fragmentation...are each in themselves good reasons to explore new paths; but when they are combined, the need to do so is urgent."

But, in dealing with present difficulties, the Report of the Task Group on Mental Retardation noted the Division of Vocational Rehabilitation responsibility to assist the community to develop and expand the programs needed. "The joint planning and close collaboration of the public and private agencies at this level are nonetheless based to a considerable extent on the funding arrangements," and further, "although the private rehabilitation facilities and workshops may solicit and receive voluntary contributions from the public, the cost of their services frequently exceeds the capabilities of private philanthropy."

The same report noted that different funding systems should be attempted for rehabilitation facilities. "Whatever the system, one of its objectives should be reducing the financial dependency of the agency on the Division of Vocational Rehabilitation for maintenance." Financing of rehabilitation agencies should be based on a schedule "more closely related to agency's costs of providing services with differential rates available based on extensiveness, depth, and quality of services provided." The implication here is that the Division of Vocational Rehabilitation's control over funding for voluntary agencies may have inhibited program growth. "If voluntary agencies were less dependent on the Division of Vocational Rehabilitation service fees they could develop programs more flexibly, explore new approaches, and dare to be more innovative and creative."

A possible answer to this dilemma lies in the very nature of federal-state funding. While authorized appropriations passed by Congress are generous, in actuality there has been a paucity of funds at the local levels. As a result, the Division of Vocational Rehabilitation was required to be selective and to provide services within a policy framework limited by budgetary considerations.

This is a national phenomenon. Table III shows the actual expenditures for 1966 and 1967, and this can be compared with the amounts authorized for the same years as shown in Table II (p. 28). New York State, like most of the others, has not until recently used its entire allotment of federal funds. In order to do so the State legislature would have to appropriate the full share of matching funds.

Third Party Funds

In commenting on state fiscal capacity and federal funding, the report of the National Citizens Advisory Committee on Vocational Rehabilitation, calls attention to unused allotments and the potential of Third Party Funds:

> "Most State funds are derived from appropriations made specifically for vocational rehabilitation. There are, however, other important sources. Public funds may be made available by transfer between State agencies or by accounting for indirect costs to the State program... A term often used is "Third Party Funds," which means that the State share of the cost of serving the handicapped...under the State plan is borne in part by a State or local public agency other than the designated State vocational rehabilitation agency...A "Third Party" agency actually obligates and disburses the funds, but it does this under the supervision and control of the State vocational rehabilitation agency. Of far greater importance is the fact that such cooperative undertakings open up new program avenues...and provide a continuum of services among programs administered by separate State agencies."[1]

Earlier in this section, alternatives were suggested which might provide "an improved arrangement of vocational rehabilitation services on a local level within the framework of current federal legislation." (See Recommendation 1c, p. 22) The role of the City of New York is important. As the National Citizens Advisory Committee's report states, another source of matching funds would be local public or private money "made available to the State Vocational Rehabilitation Agency by a political sub-division of a State to augment vocational rehabilitation services in that area."[2]

There are dangers in the widespread use of Third Party Funds. Some observers have reported that budget officials as well as legislators hold back on appropriations that they would ordinarily make. The use of Third Party Funds is to provide for expansion of services rather than as a substitute for appropriation of tax levy money.

Financial contributions of voluntary agencies can also be included in "third-party" or matching arrangements. The precise method of how this would work in New York State should be explored and its possibilities developed.

---

[1] Report of the National Citizens Advisory Committee on Vocational Rehabilitation, Washington, D.C., June 26, 1968, pp. 19-21

[2] Ibid, p. 26

To give some indication of complexities and the amount of monies involved, a sampling of 24 voluntary agencies in New York City included financial data, clients served and professional staffing. (Table IV) The sampling was based on material provided by the Greater New York Fund. Agencies included were only those who submitted data to the Greater New York Fund in order to participate in the Fund's annual giving. Some agencies related to the vocational rehabilitation aegis directly, others considered themselves as giving a rehabilitation service, and were so coded by the Greater New York Fund. However, the sample does give a fair measure of rehabilitation services provided by voluntary agencies.

TABLE IV

VOLUNTARY AGENCIES IN NEW YORK CITY OFFERING REHABILITATION SERVICES. CLIENTS SERVED, PROFESSIONAL STAFFING, FINANCIAL DATA.
(24 Agencies), 1966

Total Operating Cost	Total Income	Public Funds	*Other Income	**Client Fees	Total Clients Served	Discharged to: Employment Other	Professional Staff Full time Part time
$26,037,432	$26,196,315	$5,633,348	$20,562,967	$10,404,258	46,940	E - 5,111 O - 9,677	F - 696 P - 358

*Other Income included voluntary contributions, employment income, clients fees, etc.
**Fees are included in "other income."

CLIENTS SERVED BY BOROUGH OF RESIDENCE

Bronx	9,624
Brooklyn	13,057
Manhattan	13,625
Queens	6,646
Staten Island	324
Other areas*	3,664
	46,940

*Not all clients served were residents of New York City.

Source: Data developed from information provided by the Greater New York Fund, September, 1968 and prepared by the New York City Regional Office, Office of Planning for Statewide Vocational Rehabilitation Services, New York State Education Department.

Total operating costs are quite close to total income. In 1966, costs approached $26,037,000. Income was $26,196,000. Almost 39% of total agency income is derived from voluntary contribution, earnings, interest, and related items. This sum, $10,159,000 conceivably could be an estimate of the availability of funds for 'third-party' purposes from voluntary agencies. Using the federal matching formula, this could add an additional $40,000,000 for rehabilitation services in New York City.

Conclusions

There is no doubt that federal appropriations will increase over the next decade in order to stimulate the provision of increased vocational rehabilitation services to more disabled persons. This volume of funds requires the acceptance of at least two goals. First, that rehabilitation must be regarded as a major system, and it must be programmed accordingly. Its functional goal is to strive toward unifying related services within the concept of a service continuum that includes vocational, medical, and social elements.

Additional financial supports are possible under other federal laws. An illustration is found in the Socio-Medical Report which describes the California Model and interdepartmental funding.

Secondly, a structural goal embodies an independent agency capable of carrying out the responsibility for administration of an increasingly complicated vocational rehabilitation system. Based on projected spending levels, it is likely that between 1969 and 1975 a total of $400,000,000 will be allotted to New York State. Whether or not the State can claim this money will depend on the State's fiscal problems. New York City's share of these funds can be as much as $200,000,000. Whether or not the City can spend this sum will depend on waiver of state-wideness, joint funding, and a host of technical details which usually surround inter-agency agreements. How the voluntary agencies can contribute to the financial and program supports vital to a rehabilitation system is to be explored.

The inescapable conclusion is that the vocational rehabilitation community is being given substantially more funds to accomplish substantially greater results in serving the needs of the disabled. Vastly greater managerial inputs are needed to operate a program costing $200,000,000 than the Division of Vocational Rehabilitation's 1967 program of $18,630,965.

Planning beyond 1975 requires utilization of modern managerial tools. Systems analysis is one of them, for as Franklin A. Lindsay writes, it is "an approach to complex problems...the systematic study of all the complex elements of any given problem as an entity seen in its total perspective."[1] But, for the vocational rehabilitation community, the employment of such tools is a necessity because rehabilitation is, after all, within the framework of other interrelated systems. Because of the role it will be required to fulfill, it must have basic information on disabilities, data on individuals identified for service, accepted for service, and completed service. Correlations between specific services received, age, sex and specific disability, would be useful. Routine referrals require such inputs; standardized record keeping will facilitate them.

These are some of the tools needed; financing them is not too distant. But the goal must be accepted that rehabilitation must expand its concepts and practices to serve more people.

10 THE STATE REHABILITATION AGENCIES SHOULD UNDERTAKE GREATER EFFORTS TO PROVIDE FOR JOINT FUNDING OF REHABILITATION PROGRAMS WITH OTHER UNITS OF GOVERNMENT SHARING RESPONSIBILITY FOR CLIENT SERVICE. SIMILAR EFFORTS SHOULD BE UNDERTAKEN WITH VOLUNTARY AGENCIES.

Priority: Urgent Implementation Schedule: Interim

11 THE STATE REHABILITATION AGENCIES SHOULD EXPLORE ON A DEMONSTRATION BASIS THE EFFECTIVENESS OF ALTERNATIVE METHODS FOR THE PAYMENT OF SERVICES FOR VOCATIONAL REHABILITATION CLIENTS. ACCREDITED AGENCIES MIGHT BE GIVEN AN ADVANCE GRANT AGAINST WHICH THE DIVISION OF VOCATIONAL REHABILITATION OR THE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED COULD REFER A MAXIMUM NUMBER OF CLIENTS.

Priority: Urgent Implementation Schedule: Interim

This recommendation, supported by the Task Group for Mental Retardation, is worth exploring in order to relate agency costs to the need to develop quality services for an expanded clientele. It might also reduce the long waiting period some agencies experience in getting paid for Division of Vocational Rehabilitation purchased services and it would give more financial stability to some agencies.

12 HIGH PRIORITY SHOULD BE GIVEN BY THE STATE REHABILITATION AGENCIES FOR FINANCIAL SUPPORT TO THE DEVELOPMENT OF NEIGHBORHOOD MULTI-PURPOSE CENTERS. SUCH CENTERS BY INCLUDING SCREENING AND EVALUATION SERVICES, COULD HELP IDENTIFY AND INVOLVE DISABLED PERSONS WHO ORDINARILY WOULD NOT BE REACHED.

Priority: Urgent Implementation Schedule: Interim

Section 15 of the Vocational Rehabilitation Amendments have not been implemented as yet in New York City. In the absence of federal guidelines clarifying this section, the State Rehabilitation agency can begin planning concretely for services to the socially disadvantaged. Joint programming with the New York City Human Resources Administration and the Department of Labor can be started on a demonstration basis.

MANPOWER

Perhaps no other obstacle to effective service delivery has occasioned as much comment and concern as that of professional manpower needs. The Task Group Reports do not dwell exclusively on shortages of skilled persons: other concerns are of equal importance. These concerns ranged from professional attitudes as they contribute to institutional hardness and "bureaucratic encrustation," to the failure of many professional persons to both understand and communicate with their clients. Also included are rigid professional practices, derived, as is suggested by the Trauma and Orthopedic Handicaps Report, from the content of education courses. Attitudes on the part of some workers are reinforced by their professional organizations. The Heart Disease, Cancer and Stroke Report cites as obstacles, an "uncompromising professionalism among service groups already in existence in the field..." Dr. George A. Silver says that professional standards "become so fixed that there is a virtual lock-out and a block against the development of new forms and types of workers or the assignment of new roles for the traditional workers in order to improve the situation."

---

[1] Franklin A. Lindsay, "Managerial Innovation and the Cities," Daedalus, Issue: The Conscience of the City, Vol. 97, No. 4, Fall 1968, p. 1223

At a recent conference on utilization of rehabilitation manpower, a question was posed: "Has the trend to professionalism gone too far? Is the field of rehabilitation hampered rather than helped by the development of so many specialities...that it is largely made up of those 'experts' popularly defined as 'people who know more and more about less and less?'"[1] With professionalism almost equated to "vested interests" that are "lodged in the various disciplines," at the conference an observation was made that these interests are also "built into agency programs. They are rooted in tradition rather than in realism. Many result from a narrowness of view which limits, distorts, sometimes even negates understanding of related services."

What is needed, suggests some of the Task Group Reports, is a redefinition of job duties of professional staff and a complete review of the Division of Vocational Rehabilitation personnel programs giving attention to reappraisal of professional education requirements; recognition of supervised experience, on the job-training, and ability to meet graded work performance criteria; and recruitment and training of personnel of less than collegiate grade in the paramedical field to meet the shortages of fully qualified personnel.

A root issue posed in the Socio-Medical Report is how existing skilled manpower and finances can be redeployed or integrated in order to serve more people. Stated another way, the question is, "Is the shortage in professional manpower an artificial one that could perhaps be resolved in part by more effective manpower utilization?" No clear answer to the issue is given in the reports, but a significant possibility is found in the recommendation that calls for job redefinition. At least five reports deal with the need to establish careers for rehabilitation aides or technicians. In order to do this, job redefinition will be obligatory.

There are other recommendations which suggest a complete review of the Division of Vocational Rehabilitation professional practices and development of a planned program dealing with manpower needs. Increased salaries, relief from clerical chores, expanded recruitment in the universities, professional education leave, increased financial incentives, opportunities for promotion, leave to attend conferences, undertaking of research or advanced study, realistic civil service policies, more programmed in-service training courses as well as requiring voluntary agencies to maintain an affiliation with an academic institution are all suggestions which would help relieve the manpower crisis.

13a PROFESSIONAL ORGANIZATIONS AND SOCIETIES IN THE HEALTH FIELD SUCH AS MEDICAL SOCIETIES, PHYSICAL AND OCCUPATIONAL THERAPY GROUPS, SPEECH THERAPY ASSOCIATIONS, ASSOCIATIONS OF ORTHOPEDIC TECHNICIANS, AND OTHER SUCH RELATED HEALTH SPECIALTIES, AS WELL AS GOVERNMENTAL AGENCIES, INCLUDING THE STATE DIVISION OF VOCATIONAL REHABILITATION, THE STATE UNIVERSITY, THE DEPARTMENT OF MENTAL HYGIENE, AND OTHER STATE DEPARTMENTS CONCERNED WITH HEALTH SHOULD TAKE APPROPRIATE ACTION TO PROVIDE FUNDS, ADOPT POLICY, OR OFFER LEGISLATION TO REVISE CIVIL SERVICE REGULATIONS TO ATTRACT PERSONNEL TO HEALTH AND REHABILITATION OCCUPATIONS.

Priority: Urgent Implementation Schedule: Interim

b FUNDING SHOULD BE MADE AVAILABLE TO EDUCATIONAL INSTITUTIONS WHERE TRAINING PROGRAMS FOR THE HEALTH AND REHABILITATION PROFESSIONS DO NOT NOW EXIST SO AS TO EXPAND TRAINING OPPORTUNITIES. THIS IS IN ADDITION TO THE CONTINUED FUNDING OF TAX-SUPPORTED INSTITUTIONS WHICH ARE ALREADY PROVIDING SUCH TRAINING.

Priority: Urgent Implementation Schedule: Interim

c CONSULTATION AND PLANNING SHOULD BE HAD WITH THE STATE EDUCATION DEPARTMENT TO EASE PROFESSIONAL LICENSURE OF INDIVIDUALS TO PERMIT HEALTH RELATED PERSONNEL FROM OTHER STATES AND COUNTRIES TO TAKE POSITIONS IN NEW YORK STATE.

Priority: Urgent Implementation Schedule: Interim

---

[1] Frances A. Koestler, ed., Utilization of Rehabilitation Manpower in the Community Setting, Third Rehabilitation Workshop Proceedings, New York City Regional Interdepartmental Rehabilitation Committee, September 1967, p. 25

13d THE STATE REHABILITATION AGENCIES SHOULD PLACE GREATER EMPHASIS UPON ACQUAINTING STUDENTS IN HIGH SCHOOL AND COLLEGE THROUGH CAREER CONFERENCES IN ORDER TO ENLIST THEIR INTEREST IN AND PURSUIT OF PREPARATION FOR THE HEALTH AND REHABILITATION OCCUPATIONS.

Priority: Urgent Implementation Schedule: Interim

e TO MAKE SUCH CAREER CONFERENCES EFFECTIVE AND TO ATTRACT YOUNG PEOPLE, FINANCIAL AID BY WAY OF SCHOLARSHIPS, FELLOWSHIPS, TRAINEESHIPS, AND OTHER INCENTIVES SHOULD BE MADE AVAILABLE TO THEM. ENCOURAGEMENT SHOULD ALSO BE GIVEN TO INSTITUTING COURSES IN HIGH SCHOOLS, COLLEGES, AND GRADUATE SCHOOLS LEADING TO CERTIFICATES AND DIPLOMAS IN ALL HEALTH AND REHABILITATION FIELDS.

Priority: Urgent Implementation Schedule: Interim

f RECRUITMENT AND TRAINING OF PERSONNEL BY MEANS OF ON-THE-JOB PREPARATION FOR THE SUB-PROFESSIONAL OCCUPATIONS SHOULD BE INSTITUTED BY THE STATE VOCATIONAL REHABILITATION AGENCIES.

Priority: Urgent Implementation Schedule: Interim

g THERE SHOULD BE REAPPRAISAL OF PROFESSIONAL EDUCATION REQUIREMENTS FOR THE PURPOSE OF SHORTENING THE PERIOD REQUIRED FOR PROFESSIONAL DEGREES IN THE HEALTH AND REHABILITATION FIELD.

Priority: Essential Implementation Schedule: Short term

14 THE STATE REHABILITATION AGENCIES SHOULD REEVALUATE THE JOB DUTIES OF THEIR PROFESSIONAL STAFFS WITH A VIEW TOWARD HIRING INDIVIDUALS AT THE SUB-PROFESSIONAL LEVEL THEREBY ESTABLISHING CAREER-LADDERS FOR REHABILITATION TECHNICIANS TO SUPPLEMENT THE SERVICES PERFORMED BY PROFESSIONAL PERSONNEL. JOB TITLES WITHIN THE STATE CIVIL SERVICE SYSTEM SHOULD BE SOUGHT FOR SUCH TECHNICIANS.

Priority: Urgent Implementation Schedule: Interim

15 THE NEW YORK CITY CIVIL SERVICE COMMISSION SHOULD ESTABLISH JOB ITEMS FOR REHABILITATION AIDES TO BE EMPLOYED IN VARIOUS MUNICIPAL AGENCIES. WHEREAS THIS IDEA HAS BEEN APPROVED IN PRINCIPLE, THERE ARE AT PRESENT NO SUCH LINE ITEMS IN THE CIVIL SERVICE JOB CATEGORIES.

Priority: Urgent Implementation Schedule: Interim

16 IN DEVELOPING CRITERIA FOR AGENCY ACCREDITATION, VOLUNTARY AGENCIES SHOULD BE ENCOURAGED TO ESTABLISH A PROFESSIONAL RECRUITMENT PROGRAM AND A FORMAL AFFILIATION OR ASSOCIATION WITH A SCHOOL OR UNIVERSITY WHERE REHABILITATION IS TAUGHT. THE STATE REHABILITATION AGENCY SHOULD PROVIDE A PORTION OF THE FUNDING WHICH MIGHT BE REQUIRED.

Priority: Essential Implementation Schedule: Short Term

17 IN CONJUNCTION WITH RECOMMENDATIONS TO STRENGTHEN AND IMPROVE VOCATIONAL REHABILITATION FACILITIES AND SERVICES, THE STATE REHABILITATION AGENCIES SHOULD CONSIDER UPGRADING THEIR STAFF'S PROFESSIONAL RESPONSIBILITIES AND SALARIES. COMPETITIVE PROFESSIONAL RECRUITMENT IN THE REHABILITATION FIELD MAKES SUCH UPGRADING NECESSARY.

Priority: Urgent Implementation Schedule: Short Term

IMPROVED SERVICE DELIVERY

Broadened View of Rehabilitation

The frequency with which Task Groups have noted the necessity for viewing rehabilitation broadly, must be underscored. From a conceptual point of view, several Task Force Reports have stated in different ways, "The rehabilitation process includes the medical, social, and vocational needs of the disabled." (Heart, Cancer and Stroke) Other reports state:

> "The individual who requires rehabilitation should be viewed as a whole; his health, his environment, his culture, his education cannot be easily separated..." (Socio-Medical)
>
> "The rehabilitation process includes the teaching, guidance and direction of the...handicapped individual to enable him to achieve his optimal personal, social, educationa, psychological and vocational adjustment." (Emotionally Handicapped)
>
> "For those with...handicaps, team planning which considers clinical, social, economic and vocational needs, should be conducted..." (Respiratory)
>
> "...A suggested rehabilitation process...(shows) the various stages that a patient might pass through from the time of medical diagnosis to recovery at his optimum level of performance...it shows the early entry of vocational planning in the process and the joint participation of disciplines in the planning so that a patient is not officially 'handed over' from one department to another without group understanding and decision." (Trauma)

A broadened view of the rehabilitation process merged it into two other conceptual areas. The need to develop a service continuum for individuals requiring rehabilitation seemed to indicate that vocational rehabilitation was merely one specific service among many others.

A second view held that "there is no basic difference in approach to the vocational rehabilitation of different types of physical disabilities. There are...differentials to be considered when referrals for services are made." (Heart, Cancer and Stroke) Much the same sentiment is expressed in the Emotionally Handicapped Task Group Report which stresses that rehabilitation practitioners ought to function "less within diagnostic categories, and more in serving a client who has impaired function which results in a disability or a handicap." Emphasis should be placed on the client with function limitations, "and not to any great extent on diagnostic categories." Although Task Group Reports dealt with specific disabilities, the majority of them noted that "many or all of these services...could be provided most efficiently in facilities which would serve patients with any chronically disabling disease..." In a position paper prepared for the Addiction Task Group, it is pointed out by Dr. Efren Ramirez, Commissioner of the Addiction Services Agency, that "...the concept of vocational readiness...applies generally to all recognized disability categories such as physically disabled, emotionally disabled, mentally retarded, and 'disabled deprived'."[1]

At the first meeting of members of the Regional Advisory Committee, in December 1967, some participants expressed dissatisfaction with the structuring of the Task Groups along disability categories. Of more critical concern was the need to develop a pattern of services for those with functional limitations rather than place stress on the multiplicity of exotic and popular disease entities that capture public interest and support because of sophisticated public relations techniques or the attention certain kinds of disabilities receive from the mass media. Findings of the Socio-Medical Task Group may be quoted as a summary of the theoretical implications raised by most of the reports:

> "Assuming that disability is viewed as an individual's functional ability as influenced by his health, and 'attendant medical, psychological, vocational, educational, cultural, social, or environmental factors...,'[2] then it is essential that an uninterrupted service continuum be developed which is responsible to the total disability.
>
> "Public and private agencies offer a multiplicity of services which may be either fragmented or coordinated, duplicated or restricted. Differing jurisdictions and eligibility requirements contribute to a discontinuous service continuum which adversely affects individuals in need of help.
>
> "To accomplish integrated services, responsibility must be fixed. Legislative or administrative direction could do much to provide funding, policy guidelines and other incentives so that strengthened services could be given."

---

[1] Efren Ramirez, M.D., and Jinny Goldstein, "Addiction Services Agency Position Paper on Vocational Rehabilitation," p. 5

[2] Federal Register, United States Department of Health, Education and Welfare, Vocational Rehabilitation Administration, 31, No. 9, Part III, January 14, 1966

The implications here are threefold:

(1) Disability is viewed as functional impairment; (2) To properly serve the disabled, attention must be given to the whole person: his health, his environment, his culture, and his educational background; (3) An integrated service delivery system which will require legislative and administrative changes is indicated. The goal of a service continuum is to afford continuity of care and involvement.

The Service Continuum

The broadened view of rehabilitation imposes the need for a service continuum that cannot be achieved in isolation from the major systems and their institutions. The Task Group Reports clearly stress the need for integrated service patterns that are responsive to individual needs rather than the institutional needs of the service deliverers. A service continuum for every client would seek to involve the major systems, and agencies that relate to them, at various points of individual need. There is abundant evidence delineated in the reports that illustrates not only the need for more closely related programs, but points to the barriers to attainment.

The Mental Retardation Report states: "The services required should provide for a continuum of treatment..." The Socio-Medical Report states: "...any program answering to the needs of the handicapped, must consider a comprehensive service continuum." Implicit in the report is the idea that the socially disadvantaged in particular are the major victims of discontinuous service systems. "The seeming lack of motivation attributed to the deprived may be the result of professional and institutional 'hardness' and a failure to understand or work through cultural variances. The seeming indifference to traditional programs and services may reflect the inability of those delivering services to communicate with their respective clients." The profusion of services offered by a host of public and private agencies each with their own complex eligibility requirements and definitions of what characteristics a person must possess in order to qualify for services, might also be an effective barrier in reaching the socially deprived, as well as any other disabled person. "Differing jurisdictions and eligibility requirements contribute to a discontinuous service continuum which adversely affects individuals in need of help."

Other barriers to the service delivery system are also noted. "The absence of a service continuum that extends from doctor-hospital treatment to community-based rehabilitation services is indicative of the need to examine the system and its relationship to other programs and systems." What is needed is:

> "...a service continuum that begins with the identification of a medical disability and includes appropriate screening and medical evaluation of functional ability, and the provision of whatever services are necessary in the community which leads to independent functioning. This requires systematic attention to physical, mental, and socio-economic problems at every step along the continuum." (Heart, Cancer and Stroke)
>
> "...a continuity of services beyond hospital discharge is desirable," and when it does not take place on a large scale, "the loss by some children of gains made in clinic - when a school cannot admit them and the clinic must curtail therapy - and the absence of opportunity of other children to make any gains, weighs heavily...on staff." (Respiratory)

Although speaking about deaf school-age children, the comments made have wide applicability, and the results of fragmentation, competing jurisdictions, professional isolation and rigid policies are underscored:

> "Education facilities for deaf children with diagnosed or theorized mental retardation, emotional disturbance, and blindness are grossly inadequate. Exclusion from school may prevent the very kind of assessment which might rule out the theorized pathology...tightly-drawn admission requirements for some children cause discharge without transfer elsewhere for other children, and require needless transfers for still other children..." (Deaf, School-Age Population)

The report notes that crises situations..."result in the mobilization of some integrated, relatively comprehensive span of services in a limited number of facilities." But the absence of a service continuum with responsibility clearly fixed results in a limited program with limited impact. Many factors must be considered, and the report continues: "In some instances, a relatively adequate assessment and/or habilitation program is ready to receive a child but is not accessible to him because of the unavailability of transportation service, a very handicapping family situation, national language barriers, or other deterring factors." The report recommends "that criteria be established for proposals for any new services--such as that they have a preventive aspect, that they fit into appropriate continua and contexts of service."

In analyzing these findings there are two focal points. A rational service continuum would involve other systems, and implementing programs requiring the participation of those outside the rehabilitation orbit poses practical problems. But within the rehabilitation community, the achievement of a service continuum can be more readily implemented. Thus, the major focus of the recommendations to follow is on the vocational rehabilitation system.

18 THE STATE REHABILITATION AGENCIES SHOULD AS A MATTER OF POLICY BE REQUIRED TO TAKE RESPONSIBILITY FOR PROVISION OF CONTINUING SERVICES FOR ALL ELIGIBLE CLIENTS, REGARDLESS OF AGE, FROM PRESENTATION OF PROBLEM UNTIL THEIR MAXIMUM POTENTIAL IS REACHED. ENCOURAGEMENT SHOULD ALSO BE GIVEN TO EXPERIMENTATION OR DEMONSTRATION OF TRAINING OR RE-TRAINING OF CLIENTS WHO, ON THE BASIS OF AUTHORITATIVE PREDICTION, WILL BECOME MORE DISABLED.

Priority: Urgent Implementation Schedule: Short Term

19 IN IMPLEMENTING THIS POLICY, THE STATE REHABILITATION AGENCIES SHOULD GIVE SUCH TECHNICAL ASSISTANCE, FINANCIAL SUPPORT, AND OTHER NECESSARY SERVICES TO OTHER PUBLIC AND VOLUNTARY AGENCIES WHOSE CONTRIBUTION TO A CONTINUING CLIENT SERVICE IS IMPORTANT.

Priority: Urgent Implementation Schedule: Long Range

The first recommendation relates to internal policy, and in effect, to all the recommendations in this report that call for administrative integration of services, more effective manpower utilization, closer inter-agency links with rehabilitation facilities, improved record keeping, centralized reporting and referral. The concept of the service continuum can be developed most effectively by the Division of Vocational Rehabilitation when, in cooperation with other voluntary agencies, it begins to develop facility standards and accreditation criteria. (See Recommendations 5 and 6.)

The second recommendation would enable the Division of Vocational Rehabilitation and the New York State Commission for the Blind to offer their resources and knowledge to other related programs in very specific ways so that there will be a minimal interruption of services to the individual needing them.

The implication here is that vocational rehabilitation agencies are now required to provide services to children and older persons, offender populations and the socially disadvantaged. What specific kind of service is yet to be presented by federal guidelines; what federal appropriations will be forthcoming are still unknown. But, in developing a service continuum concept, it is possible to define just what services and funds can be contributed by public and private agencies who both have shared responsibility for the same client.

Consequently, the recommendations made in some of the Task Group Reports that urge financial supports for some health services are possible and desirable if the result is productive of a smoother transition of the client into the rehabilitation process. Similarly, early identification of disabled clients and earlier involvement of rehabilitation-oriented personnel with very young children who have handicaps can be achieved by interagency agreements that define responsibilities and augment one another's services.

Rehabilitation Facilities

Elsewhere this report advocates a broadened rehabilitation approach that would require administrative integration and the functional framework of a service continuum. Also mentioned were the kinds of rehabilitation facilities that are needed in order to deliver services. The Task Group Reports list several types, each having related but different service goals:

1. specialized rehabilitation facilities
2. comprehensive rehabilitation facilities
3. extended or terminal sheltered workshops
4. neighborhood service centers
5. medical rehabilitation facilities

At the present time, specialized and comprehensive rehabilitation facilities are routinely used by those requiring vocational rehabilitation. Extended or terminal sheltered workshops and neighborhood service centers are needed.

In the New York City Region, there are approximately 40 rehabilitation facilities which offer sheltered workshop experience, vocational evaluation, pre-vocational experience, and other services to disabled persons. Many of these facilities serve clients referred to them by the Division of Vocational Rehabilitation which purchases services for each of its clients from the agency.

Data now available from the Division of Vocational Rehabilitation shows that in the New York City area just under 1,700 DVR clients are enrolled in rehabilitation facilities at any one time. DVR statistics for 1967 reveal that the actual number of cases being served by the New York City Office was approximately 16,000.[1] Thus, more than 10 percent of the local office's clients are served by rehabilitation facilities. Based on the report of the Division of Vocational Rehabilitation Workshop and Rehabilitation Facilities Bureau, the total number of clients served by 22 of the area's 28 agencies was 6,140. Of this number, 63.2 percent were or had been DVR clients.

The Division of Vocational Rehabilitation Facilities report gives the following estimates of persons in need of Rehabilitation Workshop services for 1970, 1975:

County	1970	1975
Bronx	1416	1427
Kings	2615	2585
New York	1609	1555
Queens	2026	2091
Richmond	288	326
Total	7954	7984

Projections for 1970 and 1975 are based on the assumption that one person per 1,000 of the general population may need workshop placement. Current experience shows that each station, because of client turnover, can accommodate two persons annually. There are presently 3,460 workshop stations in the New York City Region with an annual capacity of approximately 6,900 persons. This means that in order to meet the need to serve the estimated 7,984 persons, the number of present stations (3,460) would have to be increased by 542 by 1975.

However, it can be concluded that this is a minimal estimate. Since the estimate is keyed to future population trends and does not take into consideration an increase in demand if more clients were found eligible for DVR-CBVH sponsorship, the estimate is low. Demand would undoubtedly increase if better casefinding and intake procedures were instituted and if account were taken of the need for workshop services for the disadvantaged. There is also the question of the turnover rate. Some observers in the workshop field suggest that a more realistic rate might be 1.5 persons per station per year.

Before discussing the problems of generalized versus specialized agencies, a word must be said about their clients. As shown above, 36.8 percent of the rehabilitation facility caseload was not sponsored by the Division of Vocational Rehabilitation. The persons served, however, are disabled, but not all of them eligible for sponsorship. They may be too old, too young, they may be paying for services privately, or they may have been rejected by, or were former clients of the Division of Vocational Rehabilitation services.

Specialized Rehabilitation Facilities

Despite the trend to remove the disabled from specialized and isolated programs, there was agreement in many of the Task Group Reports that specialized facilities are still needed and necessary. For some disabilities specialized services must be expanded, and specialized personnel must be recruited and trained. The direction here is that specialized facilities and programs are necessary to bring the handicapped person to a functional level so that he can gradually progress to more generalized and comprehensive constellations of service.

For some disability categories, such as the deaf or those with communications disorders, the mental retardates, or other disabilities, where there is onset at an early age, involvement in specialized facilities must begin early so that by the time the disabled person approaches vocational decisions, he will be prepared for the transition into independent living and employment.

Comprehensive Rehabilitation Facilities

Adapted to meet the needs of handicapped people with varying functional abilities, comprehensive, or generic, agencies service people with different kinds of disabilities. There has been a tendency for some groups of disabled to resist participation in programs that included other disability groups. For instance, at a meeting of the Addictions Task Group, it was noted that the drug addict and the alcoholic do not seem to get along well with one another. Similar observations are reported with other disability groups. For the mentally retarded and the blind there is a tendency on the part of some facilities to exclude them from their programs because of client attitudes and probably more significantly, the agencies were not prepared to meet their needs.

---

[1] New York State Workshops and Rehabilitation Facilities Plan, The University of the State of New York, The State Education Department, September 1968

The comprehensive agency, however, has been most effective for several reasons. It attempts to create a more realistic environment. Professional staff is apt to be multi-disciplinary and the client is required to adjust to others who are unlike himself. Thus, Altro Workshops will serve respiratory, cardiac, mentally retarded, emotionally disturbed, and socially disadvantaged clients. United Cerebral Palsy of Queens is another excellent example of a comprehensive facility which started initially by serving a specific group, but later included other disabilities.

Geographic factors also play a role. The absence of facilities in some areas will lead an established agency to offer services to other disability groups. In Staten Island, where there are no rehabilitation facilities, it is likely that a comprehensive facility would be indicated.

20 THE STATE EDUCATION DEPARTMENT SHOULD ASK THE COMMUNITY COUNCIL OF GREATER NEW YORK TO COMPILE AND PUBLISH AN INVENTORY OF ALL REHABILITATION FACILITIES IN EACH BOROUGH. THE INVENTORY SHOULD INCLUDE THE NUMBER OF CLIENTS SERVED, CAPACITY, AND A CONCISE DESCRIPTION OF AGENCY SERVICES. THE STATE EDUCATION DEPARTMENT SHOULD PROVIDE APPROPRIATE FUNDS FOR THIS PROJECT.

Priority: Urgent Implementation Schedule: Interim

21 THE STATE REHABILITATION AGENCIES SHOULD ADOPT A POLICY OF ENCOURAGING DEVELOPMENT OF AND GIVING FINANCIAL SUPPORT TO VOLUNTARY AGENCIES FOR THE EXPANSION OF COMPREHENSIVE SERVICES.

Priority: Urgent Implementation Schedule: Interim

Those with multiple disabilities can more easily be accommodated in a comprehensive agency because they usually can offer the skills of several professional disciplines within one physical setting.

22 THE STATE REHABILITATION AGENCIES, WITH THE ASSISTANCE AND PARTICIPATION OF EXISTING REHABILITATION FACILITIES IN THE NEW YORK CITY REGION, SHOULD STUDY THE CAUSES OF THE CURRENT UNEVEN UTILIZATION OF REHABILITATION FACILITIES.

Priority: Urgent Implementation Schedule: Interim

Several Task Group Reports dealt with the Division of Vocational Rehabilitation utilization patterns. As one report indicates, there may be a question as to the adequacy of such facilities. A study of their capacities, services, staffing, equipment, and operating procedures is indicated. From this, meaningful standards can be developed. Another Task Group suggested that the Division of Vocational Rehabilitation counselor attitudes might influence utilization of certain facilities and that these attitudes are not objective.

The interpretation of Task Group Reports indicates that in its relationship with rehabilitation agencies, the Division of Vocational Rehabilitation has developed an administrative insularity and unresponsiveness. There are several recommendations that point to this and the majority of the reports include comments which tend to view the Division of Vocational Rehabilitation as being uneven in some of its operations.

The Workshops and Rehabilitation Facilities Plan released by the Division of Vocational Rehabilitation indicates that 28 rehabilitation agencies operate 39 workshops. Of the 22 agencies submitting data, there was an average daily client census of 2,680 during 1967. The workshops reporting in New York City "...were operating at 80.1 percent of maximum capacity--an increase compared to last year's figure which was approximately 74 percent."[1]

In the Regional Executive Committee discussions there were some reservations about adopting this recommendation. It was felt that a more complete inventory of rehabilitation facilities together with staffing patterns, client capacity, program and service content should be available to serve as a factual base that would make the study more objective. In adopting the recommendation, it was noted that data about the agencies currently providing services is now available, and a review of utilization patterns would be useful.

---

[1] Op. Cit., Rehabilitation Facilities Plan

23 THE STATE REHABILITATION AGENCIES SHOULD, ON A PRIORITY BASIS, FULLY SUPPORT THE ESTABLISHMENT OF A REHABILITATION WORKSHOP SERVING A NUMBER OF DISABILITIES, WITHIN A BUSINESS PLANT.

Priority: Urgent Implementation Schedule: Interim

The business community should be involved in the training of disabled persons on a larger scale than has been undertaken in the past. Realistic industrial settings cannot always be duplicated in workshops operated by non-profit agencies. The desirability of a rehabilitation workshop located on the premises of a business enterprise has many advantages. The sharing of responsibility by business and professional groups, the cross-fertilization of working with rehabilitation technicians, and an opportunity that would lead the disabled person into a direct placement with industry are among these benefits.

Under present policy, the Division of Vocational Rehabilitation can fund such facilities and purchase services from industry. Construction, innovation, and other grants are available. In one or several of these business-operated facilities, the Division of Vocational Rehabilitation can assign some professional staff.

24 THE STATE REHABILITATION AGENCIES SHOULD DETERMINE THE NEED FOR EXPANSION OR ADDITION OF FACILITIES IN AREAS NOT NOW ADEQUATELY SERVING VARIOUS DISABILITY GROUPS.

Priority: Urgent Implementation Schedule: Interim

Abundant facilities are available in many parts of New York City, but other areas have none. For the vocational rehabilitation community, there is no concise directory of agencies that informs as to whether they are general agencies or specialized, or what kinds of services are offered or how many clients are served or what their disabilities may be.

25 THE STATE REHABILITATION AGENCIES SHOULD CONTINUE WORKSHOP IMPROVEMENT GRANTS AND OTHER VITAL SUPPORTS OR GRANTS TO REHABILITATION FACILITIES TO ENABLE THEM TO ACCOMMODATE LARGER NUMBERS OF CLIENTS.

Priority: Urgent Implementation Schedule: Interim

Extended Sheltered Workshops

Among the various types of rehabilitation workshops, the extended care, or terminal workshop, is needed. Many disabled persons can not be brought to a level of performance so that they can be employed in usual situations. They are so seriously disabled that they can rarely fit into a structured and competitive labor market. At the present time, many workshops continue to provide meaningful work experiences over a long period. Because some workshops have limited capacity or cannot afford to carry a severely handicapped person, financial support is needed. The purpose of the extended care workshop is to enable the handicapped person to be employed outside the home at some task, rather than do nothing.

At this time, we do not know how many people will need or want service in such a facility, nor is there sufficient objective data that would indicate what the utilization problems might be.

26 THE STATE REHABILITATION AGENCIES SHOULD PLAN FOR THE DEVELOPMENT OF LONG-TERM SHELTERED WORKSHOPS FOR THE SEVERELY DISABLED BY SPONSORING NEEDED LEGISLATION, OR TAKE OTHER APPROPRIATE MEASURES TO ENCOURAGE AND ESTABLISH SUCH FACILITIES. CONSIDERATION SHOULD BE GIVEN TO A POLICY OF MAKING LONG-TERM WORKSHOPS A PART OF OR LINKED TO LARGER FACILITIES TO INSURE A REHABILITATION APPROACH TO SERVICES. (See Recommendations A-8, T-7, B-18d in Part II.)

Priority: Essential Implementation Schedule: Long Range

27 IN PREPARATION FOR PROGRAMS DEALING WITH ESTABLISHING WORK EVALUATION AND ADJUSTMENT SERVICES, THE STATE REHABILITATION AGENCIES SHOULD BEGIN PLANNING WITH APPROPRIATE NEW YORK CITY AGENCIES SUCH AS THE HUMAN RESOURCES ADMINISTRATION, THE COMMUNITY MENTAL HEALTH BOARD AND OTHER DEPARTMENTS IN THE HEALTH SERVICES ADMINISTRATION.

Priority: Urgent Implementation Schedule: Interim

In developing such a plan, attention should be given to the kinds of disabilities to be served, the functional residuals needed, whether older persons should be included, and, as the Trauma Task Group suggests, whether on a demonstration basis one such workshop could be located in each borough.

In addition, the Trauma Task Group suggests that workshops should be closely connected to established rehabilitation facilities, and thus benefit from the experience and economics accruing from supervision by established agencies. In addition, for some persons placed in an extended workshop facility, it is possible that there would be developed the ability and skills to facilitate transfer to a more competitive setting.

Neighborhood Multi-Service Centers

Multi-service centers located in various neighborhoods offer an opportunity to accommodate greater numbers of the Socio-medically handicapped. As the Socio-Medical Report indicates, there are several different kinds of neighborhood centers currently in operation or in the process of development by various New York City agencies. In some instances some of these centers can be used to include one or more of the essential services required by the handicapped. Its value to the rehabilitation community is that, with effective screening and evaluation facilities, the center would be able to identify and reach out to disabled persons who ordinarily would not be reached.

The Task Group for the Emotionally Handicapped also mentions the various Community Mental Health Centers which are presently in the planning phase, but which will be operating on an expanded scale by 1972. The report urges that these centers also serve those with any disability.

In the Senate Report previously mentioned (Report No. 1309), a facility for providing vocational evaluation and work adjustment was described as being operated either by the state rehabilitation agency or by contract with a voluntary agency. Staffing would be multi-disciplinary and include sub-professionals "who will include assistants to the professional workers, community contact workers, and so forth." While primarily regarded as an evaluation center that provides a variety of vocational experiences, it is contemplated that such centers will accept referrals from other agencies, and that reciprocal referrals will be made to the rehabilitation agency.

The Neighborhood Center envisioned under Title 15 will be included in the federal guidelines. The Senate Committee, in adopting the section on vocational evaluation and work adjustment, made the suggestion that

> "the Rehabilitation Services Administration keep separate statistical data as to services provided to the new category of individuals proposed to be served by vocational rehabilitation agencies. By this separation of statistics there will be little possibility of confusion as to the number of physically and mentally disabled persons served, and the numbers of otherwise disadvantaged persons served by vocational rehabilitation services."

However, the City of New York is proceding with its planning for Multi-Service Centers, and the Division of Vocational Rehabilitation can expand its services to these centers. At the present time the Division of Vocational Rehabilitation is involved in staffing arrangements with the pending Central and East Harlem Concentrated Employment Projects.

These efforts are by no means all the types of center operations which can serve the disabled or the disadvantaged. Both the Socio-Medical and the Emotionally Handicapped Reports have given models of centers which can be used in various neighborhoods. They may be either engrafted onto existing centers operated by other agencies or phased into future development.

The Engler model, discussed in the Appendix to the Emotionally Handicapped Report, does have some innovations which are of interest. While the approach used has a psychiatric orientation, it is applicable to many disabilities. Support for such a therapeutic community is found in an article by Elaine Rosenfeld, who points to the great "interest in discovering ways of using interaction in group settings and of managing social settings." She states:

> "There is another base from which treatment can develop and that is increased role adequacy and rehabilitation, thus emphasizing capacities rather than disabilities. It is from this base of capacities, rehabilitation and increased role adequacy, that the therapeutic community has evolved and developed."[1]

The models presented and their underlying concepts represent the kinds of innovative approaches that can be adapted to multi-service centers. The increasing interest of the behavioral profession in practical rehabilitation is significant for a disabled population, many of whom have multiple handicaps, not the least of which may be those of an emotional nature.

---

[1] Elaine Rosenfeld, "The Therapeutic Community: An Environment to Promote Mental Health," Youth Service News, New York State Division for Youth, Vol. 19, No. 3, Summer--1968

28 THERE SHOULD BE DEVELOPED IN EACH BOROUGH A MULTI-SERVICE VOCATIONAL EVALUATION AND WORK ADJUSTMENT PROGRAM AS ENVISIONED IN THE 1968 VOCATIONAL REHABILITATION ACT AMENDMENTS. WHERE FEASIBLE, SUCH PROGRAMS SHOULD RELATE TO MODEL CITIES MULTI-SERVICE CENTERS WHERE THESE ARE DEVELOPED.

Priority: Urgent — Implementation Schedule: Interim

29 THE STATE REHABILITATION AGENCIES SHOULD UNDERTAKE A BROAD STUDY THAT WILL RESULT IN THE DEVELOPMENT OF STANDARDS FOR THE OPERATION AND FUNCTION OF DIAGNOSTIC AND EVALUATION CENTERS WITHIN HOSPITAL FACILITIES THAT RELATE TO VOCATIONAL REHABILITATION.

Priority: Essential — Implementation Schedule: Short Term

Medical Rehabilitation Facilities

The Division of Vocational Rehabilitation is studying selected medical rehabilitation facilities in the New York City area which "have the potential of being utilized."[1] Of the area's 39 workshops operated by 28 agencies, there are seven workshops in as many medical facilities. Among them are Montefiore Hospital and Medical Center, and the New York Medical College, Center for Chronic Diseases. Other vocational rehabilitation programs are to be found in Downstate Medical Center and the Psychiatric Division of Harlem Hospital.

Because under existing federal law (PL 90-391) hospitals may establish a rehabilitation facility, there is ample opportunity in the future to develop improved diagnostic and evaluation services as well as a range of comprehensive rehabilitation services that include under one management, medical, psychological, social and vocational services.

Related to medical rehabilitation facilities are those being developed by the New York State Department of Mental Hygiene and the New York City Community Mental Health Board. These agencies and the Division of Vocational Rehabilitation are in the process of planning for the establishment of vocational rehabilitation services within neighborhood-based community mental health and mental retardation centers. Twelve mental health centers in New York City are in various stages of planning and completion; 43 are programmed. Four mental retardation facilities are similarly underway; 10 are programmed. The extent to which the State Rehabilitation Agencies are able to provide vocational rehabilitation services will, of course, be determined by the availability of funds.

There is no doubt that with ample resources, medical, mental, and mental retardation facilities can undertake a broader role in providing effective rehabilitation; these service deliverers are in an excellent position to develop a service continuum for their clients.

Improved Diagnosis and Evaluation Services

Significantly, many of the Task Group Reports, while stressing the need for a client service continuum, noted the importance of adequate diagnostic and evaluation facilities. This need was of equal importance for the delivery of clinical services as it is for vocational rehabilitation services.

> "Evaluation centers so staffed as to be able to give comprehensive evaluation and a detailed program of care for each patient—preferably should be so organized that they can serve private, insured or indigent uninsured patients."(Arthritis)
>
> "An essential element in the development of a service continuum lies in adequate patient evaluation. If after evaluation of each patient's functional capacity it is determined that specific services are indicated, appropriate referrals can be made." (Heart, Cancer and Stroke)
>
> "A team approach, with appropriate diagnostic equipment is probably the most effective way of providing evaluations." (Heart, Cancer and Stroke)

Similarly, the Task Group report dealing with the Blind and Visually Impaired, mentions the need to "develop better evaluative services." For those with orthopedic and related problems, a "...team of specialists could undertake an extensive work-up of the patient and made expeditious referrals..."

The Socio-Medical Report states: "Screening techniques will have to be developed to determine whether or not a client should have a vocational rehabilitation program." This report, dealing with the disadvantaged, presents another important aspect of the need for evaluation services for those who are not seriously impaired by physical disability. The issue raised is directly related to the amendments of the Vocational Rehabilitation Act passed in 1968 (PL 90-391) which require the states to provide vocational evaluation and work adjustment programs for those who are physically or mentally handicapped or disadvantaged because of youth, age, low educational attainment, ethnic, prison or delinquency histories. The Socio-Medical report goes to the extent of specifying that "...thorough evaluation, screening and diagnostic services" should be provided in neighborhood multi-service centers.

---

[1] Op. Cit., Rehabilitation Facilities Plan

In the report for the Hard of Hearing, attention is directed to the relationship between the need to have better definitions of disabilities, the lack of quantative incidence data, and the need to determine functional limitations in order to obtain better evaluation of client potentials for service. The report states:

> "...much more information is needed concerning the extent of impairment and the needs for rehabilitative services resulting from associated handicaps. Better evaluation and classification is needed based on functional limitations...that must be precisely defined if habilitation and rehabilitation is to be meaningful."

As the recommendations to follow suggest, there is a need to expand diagnostic and evaluation services that have a focus on vocational rehabilitation. For those services which provide for feeding into the rehabilitation process, the Task Groups indicate more tangible involvement by the vocational rehabilitation agencies. Along with fixing standards for diagnostic and evaluation services, the Division of Vocational Rehabilitation should also provide some funding and staffing arrangements. A model that should be explored more fully in developing these standards would be England's industrial evaluation units.

At the same time, closer scrutiny should be paid to the programs which do provide evaluations. These are Workmen's Compensation (the Bureau of Disability Determinations), the Primary and Secondary Rehabilitation Centers, programs dealing with the military rejectee, and the Department of Social Services' Aid to the Disabled.

For each of these programs, diagnosis and evaluation of clients is made to determine eligibility for benefits. Evaluation of vocational potential is made, and many of these programs have agreements with the Division of Vocational Rehabilitation to provide needed services. It is not possible at this time to give any data which show the number of persons evaluated, the number for whom vocational rehabilitation has been recommended, the number who are willing to accept rehabilitation services, and the number who are actually referred and finally accepted by DVR. Unofficial statements by the people close to these programs conclude that much more can be done.

30 THE STATE REHABILITATION AGENCIES SHOULD CONSIDER FINANCIAL SUPPORTS TO UPGRADE EVALUATION AND REFERRAL SERVICES IN THE PRIMARY AND SECONDARY REHABILITATION CENTERS.

Priority: Urgent Implementation Schedule: Short Term

The importance of the Primary and Secondary Rehabilitation Centers is noted. For a further analysis of their patient load, staffing, and referral services, see pages 117-124 of this report. Permitting vocational rehabilitation counselors to establish eligibility has already been recommended. By outstationing DVR staff in these centers, immediate implementation of at least part of this recommendation is possible.

31 THE STATE REHABILITATION AGENCIES SHOULD AUTHORIZE QUALIFIED VOCATIONAL REHABILITATION COUNSELORS WHO ARE EMPLOYED IN THESE CENTERS TO DETERMINE ELIGIBILITY FOR SERVICES UPON DISCHARGE FROM THESE CENTERS.

Priority: Urgent Implementation Schedule: Short Term

32 THE STATE REHABILITATION AGENCIES SHOULD DETERMINE THE NEED AND THE AMOUNT OF FUNDING FOR THE OUTSTATIONING OF REHABILITATION COUNSELORS IN EVALUATION CENTERS IN ORDER TO UPGRADE THE REFERRAL PROCEDURES FOR THESE CENTERS. (See Recommendations T-6; HCS-5, 8, 15, 16; R-2, 3, 5; A-1, 2a.)

Priority: Urgent Implementation Schedule: Short Term

33 THE STATE REHABILITATION AGENCIES SHOULD CONSIDER FINANCIAL SUPPORT FOR THE DEVELOPMENT OF A UNIFORM REPORTING SYSTEM.

Priority: Urgent Implementation Schedule: Short Term

EXPANDED VOCATIONAL REHABILITATION SERVICES

In practice, the person seeking vocational rehabilitation services is handicapped by a physical or mental condition that interferes with his ability to work or to engage in satisfying daily activities. But June 1968 saw the passage in Congress of legislation which made eligible for vocational rehabilitation services those with social handicaps.

> "A new program is established, to serve the disadvantaged, including youth of school age with mental or physical disabilities, as well as those who have behavioral problems, or are gross underachievers, or are socially maladjusted as a result of environmental deprivation."[1]

The program referred to in the 1968 Amendments to the Vocational Rehabilitation Act (PL 90-391) is described in Section 15 and titled "Vocational Evaluation and Work Adjustment Program." Essentially, this program relates to those people who are not disabled by a physical or mental condition. For this group the disability is primarily of a social nature.

Interestingly enough, several of the Task Groups grappled with the problems relating to providing services to the disadvantaged. Congressional fiat resolved the issue by mandating a program for those with social disabilities within vocational rehabilitation legislation. Such a dimension adds to the concept of disability and cuts across several jurisdictional and administrative boundaries, which predictably will have an impact on service delivery systems.

The planning task becomes complicated when consideration is given to formidable conceptual and service changes which must be made in order to provide expanded services to those with "traditional" disabilities within an imperfect system.

To serve those with social disabilities requires different approaches, new adaptations, and service integration and coordination on an expanded scale. Many of the Task Group Reports deal with this problem. The practice of medicine, the existence of specialized health agencies and specialized governmental units seem to be organized around categorical disabilities. The reports touch on this issue with varying depth.

Requiring the treatment by the vocational rehabilitation field (which has had an extremely close relationship to the health field) of social and environmental factors which disable individuals may create philosophical as well as pragmatic advances in several areas. With few exceptions the reports take the view that vocational rehabilitation must deal with the total man. Services are for problemed people; problems are frequently multiple and may include those of a medical, mental, financial, educational or a familial or environmental nature. In practice, vocational rehabilitation has dealt with each of these problems, and it is for this reason a sequential pattern of services is stressed in many of the reports. Fragmentation of services often creates barriers to client involvement. Inconsistent agency goals, public and private, create a labyrinth of eligibility requirements. Lack of uniform terminology and record keeping hamper communication between professional and client.

There are other problems in service delivery. A wealth of information has been studied and many proposals have been made to extend the upper and lower age limits for rehabilitation services. The Congressional Committee on Labor and Public Welfare reporting on HR 16919, the 1968 Amendments to the Vocational Rehabilitation Act, stated:

> "It has, for instance, long been evident that youth of school age with physical or mental disabilities have not been adequately prepared for making a satisfactory vocational adjustment in the community. There is a need to expand services for these individuals, not only for those who have clear-cut physical and mental disabilities, but also for those who have behavioral problems, who are gross underachievers, who are educationally and culturally impoverished as a result of little or no parental stimulation, or who are socially maladjusted as a result of environmental deprivation. The vocational rehabilitation agency, with long and successful experience in providing comprehensive evaluation services to its clients, is the best equipped by working philosophy and experience to provide these kinds of services."

As for senior citizens, the legislation is less specific. It includes "individuals disadvantaged by reason of their youth or advanced age" as being eligible for the vocational evaluation and work adjustment program.

Conceptual Conflicts

From a review of Task Group minutes, discussion during committee meetings, and from reports, a common concern is revealed. The practitioners in the vocational rehabilitation field are deeply concerned about how services to the socially disadvantaged could be developed. There was recognition that much remains to be done in perfecting traditional services to the physically and mentally disabled. For this latter group, urgent needs for service improvement are recognized and accomplishing them seems to be a long way off.

---

[1] Vocational Rehabilitation Amendments of 1968, pamphlet, Department of Health, Education and Welfare, Rehabilitation Services Administration, Washington, D.C., 1968

There is a question as to whether the vocational rehabilitation community could absorb new groups of clients for whom new services and new approaches would be necessary. The vocational rehabilitation discipline places heavy emphasis on one-to-one counseling, and in the face of professional manpower shortages and the need for adequate funding, serving the disadvantaged in large numbers would be most difficult. Fear was expressed that the counseling aspect of rehabilitation would be diluted and that an emphasis on serving numbers within short periods of time would be inappropriate. In short, the rehabilitation community is presently in a process of trying to consolidate and improve its techniques, its efficiency and professional skills in order to serve greater numbers of the physically and mentally disabled and the mentally retarded. Amid this fluid state a mandate to serve other client populations creates formidable problems.

Tooling up for an ever wider rehabilitation effort, with the need to explore staffing patterns, the kinds of facilities necessary, and the costs are overwhelming considerations. But just as perplexing is the host of attitudinal and logistical problems. Jurisdiction and roles of private and governmental agencies, the nature and consistency of governmental support, ferment and uncertainty in approaches to urban crises are all factors that make the vocational rehabilitation community uncomfortable, and perhaps threatened.

The Task Group Reports recognize that these issues must be considered in developing a State plan for vocational rehabilitation services. Some solutions have been suggested in the Task Group Reports. What follows are a series of recommendations that impose a mandate on the rehabilitation community to expand their services to the physically, mentally and socially handicapped client.

Expanded Case-Finding

34 IN SETTING STANDARDS FOR REHABILITATION AGENCIES, THE DIVISION OF VOCATIONAL REHABILITATION SHOULD INCLUDE PROVISIONS THAT PLACE EMPHASIS ON CASE-FINDING BY VOLUNTARY AGENCIES.

Priority: Urgent Implementation Schedule: Short Term

In the Mental Retardation Report some emphasis was placed on the need for voluntary agencies to be more independent from the Division of Vocational Rehabilitation. Another aspect of the patterns of referral creates this dependency too. Many agencies depend on DVR to send its clients to them, and consequently, they do not seek out referrals systematically.

35 THE STATE REHABILITATION AGENCIES SHOULD ALSO DEVELOP INCREASED CASE-FINDING EFFORTS BY GIVING SYSTEMATIC ATTENTION TO: PUBLIC INFORMATION AND EDUCATION FUNCTIONS, COMPREHENSIVE REFERRAL SYSTEM, UTILIZATION OF A DISABILITY REGISTER, AND THE DEVELOPMENT OF ROUTINE REFERRAL PROCEDURES WITH OTHER GOVERNMENT AGENCIES.

Priority: Essential Implementation Schedule: Short Term

Any aggressive case-finding program requires not only planning, but adequate staff support. The techniques for case-finding can be built into an integrated program, as is shown in the recommendation above, which in turn depend on a series of preceding suggestions. Case-finding, it is shown, cannot be a single program element, but it is part of a larger program which should be delegated and responsibility for implementation established. Practically, however, a planned case-finding program will be necessary. Target populations will have to be determined on the basis of back-up facilities, staff and funds.

36 AS PART OF ITS CASE-FINDING EFFORT THE STATE REHABILITATION AGENCIES AS WELL AS VOLUNTARY AGENCIES, SHOULD BE ENCOURAGED TO ESTABLISH "OUTREACH" PROCEDURES.

Priority: Essential Implementation Schedule: Short Term

"Outreach,""referral," and "advocacy" are terms used in PL 90-391. Their precise meaning is as yet undefined. Yet, their clear import is that outreach and case-finding are quite similar, that referral is as much a part of case-finding as outreach, and that advocacy has a very direct relation to caseholding as well as case acceptance.

37 THE STATE REHABILITATION AGENCIES SHOULD EXPAND OUT-STATIONING OF VOCATIONAL REHABILITATION COUNSELORS IN APPROPRIATE HOSPITALS, REHABILITATION FACILITIES, SCHOOLS, MULTI-SERVICE CENTERS ORIENTED TOWARD REHABILITATION, AND OTHER AGENCIES PUBLIC OR PRIVATE WHERE THERE ARE LIKELY TO BE LARGE NUMBERS OF CLIENTS.

Priority: Urgent Implementation Schedule: Short Term

38 THE STATE REHABILITATION AGENCIES, AS PART OF THEIR CASE-FINDING EFFORTS, AND AS PART OF SYSTEMATIC INTAKE PROCEDURE, SHOULD PROVIDE EACH APPLICANT FOR SERVICE WITH A CLEARLY PRINTED BOOKLET THAT DESCRIBES SERVICES FOR WHICH HE MAY BE ELIGIBLE AND INCLUDE A SIMPLE DESCRIPTION OF PROCEDURES, SERVICES AVAILABLE AND WHAT THE CLIENT MIGHT EXPECT, AS WELL AS PROCEDURES FOR THE ADMINISTRATIVE REVIEW OF AGENCY DECISIONS. THIS BOOKLET SHOULD ALSO HAVE A SPANISH LANGUAGE EDITION.

Priority: Urgent | Implementation Schedule: Interim

It is the purpose of this recommendation to suggest that case-finding requires some publication which people interested in vocational rehabilitation should be able to read at leisure and in a language they can understand. At the same time, the publication ought to be attractive, graphic, and illustrated. The present single page description of DVR services is inadequate. Not only should a publication be attractive, it should be informative. It should not only describe the services offered by the agency, it should describe the steps that the potential applicant must take, it should advise him of his rights to appeal decisions he does not agree with.

Services to Children

On page 14 of this report, the extent of services to children provided by the Division of Vocational Rehabilitation was noted. Each of the Task Group Reports, except two, noted the almost complete lack of concerted vocational rehabilitation services to children. The issue is a complicated one because other agencies are also responsible for services to children. It is only since 1965 that DVR was permitted to offer vocational rehabilitation services to children under 14 years of age. There are three key agencies which ought to be involved in a much closer relationship with DVR. These are the New York City Board of Education, the New York State Education Department's Bureau of Handicapped Children, and the New York City Health Services Administration.

In the Mental Retardation report there is a substantial outline of the kinds of services required. The Heart Disease, Cancer, Stroke Report also gives specific recommendations indicating at what age services should be offered, and suggests that the school system is the best source for the identification of handicapped children who may be potential candidates for vocational rehabilitation services at a future time.

In the Blind and Visually Handicapped Task Group Report there is a most concise statement of how the vocational rehabilitation agencies can provide a service to youngsters starting at a very early age:

> "Services for young children and adolescents must be considered by the vocational rehabilitation agencies. Collaborative programs should be developed by the New York City Board of Education, VRS and DVR, so that children can be prepared to enter educational sequences at proper age levels..."
>
> "For adolescents, it is not always possible to obtain services. However, those who require it are served by VRS and DVR, but a study should be undertaken so that all persons in this age group who are in need of service, irrespective of whether they are seeking it, be brought into applicable programs." (See Recommendation B-17.)

39 VOCATIONAL REHABILITATION SERVICES FOR CHILDREN UNDER 14 YEARS OF AGE SHOULD BE PROVICED BY THE VOCATIONAL REHABILITATION AGENCIES, AND WHERE OTHER GOVERNMENT DEPARTMENTS HAVE A RESPONSIBILITY FOR THEIR YOUNG CHARGES OR CLIENTS, INTERAGENCY AGREEMENTS FOR COST-SHARING AND PROGRAM DEVELOPMENT SHOULD BE UNDERTAKEN. (See Recommendation B-17.)

Priority: Urgent | Implementation Schedule: Short Term

40 AS A MATTER OF POLICY THE DIVISION OF VOCATIONAL REHABILITATION AND THE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED SHOULD CONSIDER INCREASED SERVICES TO DISABLED ADOLESCENTS AND UNDERTAKE THE ESTABLISHMENT OF JOINT PROGRAMS WITH THE NEW YORK CITY BOARD OF EDUCATION IN RENDERING MORE EXTENSIVE GUIDANCE AND THE PROVISION OF BUSINESS, TRADE, AND VOCATIONAL CLASSES WITHIN THE REGULAR SCHOOL SYSTEM. (See Recommendation T-4.)

Priority: Essential | Implementation Schedule: Short Term

It is possible to avoid repetition of many problems in later life, if priority were given to the teenager whose need for intensified service is apparent. In implementing these recommendations, agreements between participating agencies should include professional assignments, course content, joint staff sharing, and allocation of costs.

Services to the Aged

As with youth, vocational rehabilitation services for the older person are minimal. Division of Vocational Rehabilitation service characteristics reveal a tapering off of persons accepted after age 55. Of the 8,505 persons rehabilitated in New York State in 1964-1965, the median age at acceptance was 31. Those between 55 and 64 years of age numbered 729, or 8.6% of those rehabilitated. After age 65, 206 persons, or 2.4% of the caseload, were rehabilitated.[1] Whether this represents the age profile of the total undercare caseload is unknown. The supposition is that it does.

The new Vocational Rehabilitation Act Amendments under Section 15, The Vocational Evaluation and Work Adjustment Program, considers "individuals by reason of their youth or advanced age" to be disadvantaged, and hence eligible for services under this Section. Hopefully, the guidelines will resolve some of the problems created by including older persons in a section of the law designed for those with social impediments.

The Task Group Reports are mindful of the growing older population made up of people who have had substantial employment histories. For this group of people there are several differential factors. For those retired people who wish to supplement their income by working, programs are needed; for older persons with disabilities who wish to work, programs are needed; for older persons with avocational interests, programs are needed. Paradoxically, under present policy, vocational rehabilitation services are only available to those in the middle category.

The question is to determine the extent of programs or services which DVR and VRS should offer in conjunction with the State, Federal and New York City Office for Aging, and with the local Golden Age Clubs and other interested groups.

41 THE VOCATIONAL REHABILITATION AGENCIES SHOULD UNDERTAKE A STUDY IN COOPERATION WITH VOLUNTARY AGENCIES TO DETERMINE THE NEED FOR VARIOUS PROGRAMS FOR THE AGED, SOURCES OF FINANCIAL SUPPORT, AND SPECIFIC TYPES OF SERVICES TO BE OFFERED.

Priority: Essential — Implementation Schedule: Short Term

42 IN BROADENING THE SCOPE OF SERVICES TO BE PROVIDED BY VOCATIONAL REHABILITATION PROGRAMS, LEGISLATION SHOULD BE ENACTED THAT WOULD PERMIT THE STATE REHABILITATION AGENCIES TO ESTABLISH PROGRAMS WITH VOLUNTARY AGENCIES THAT WOULD PROVIDE FINANCIAL SUPPORT FOR SERVICES THAT FOSTER INDEPENDENT LIVING FOR DISABLED PERSONS OVER 60 YEARS OF AGE WHO DO NOT MEET PRESENT DIVISION OF VOCATIONAL REHABILITATION - COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED ELIGIBILITY REQUIREMENTS. (See Recommendations T-9 and B-18.)

Priority: Essential — Implementation Schedule: Long Range

Preventive Services

There has been considerable discussion in the health professions about the value of preventive medical services. For the vocational rehabilitation field, there are other aspects. Preventive services mean accepting the fact that an individual has a disability, assuring that he will have adequate medical treatment, and at the same time preparing the person early in life, or as soon after onset of disablement, for a vocational pursuit. It is for this reason that some of the Task Group Reports advocate early involvement with the handicapped child, and for the same reason a disability register is advocated.

Recommendations dealing with the disability register (R3), uniform record keeping (R4b), comprehensive referral service (R2), adequate case-finding (R34, R35) and services to children (R39, R40), are applicable for this Section.

Improved Placement and Follow-Up

There has been some implication that the two final steps of the rehabilitation process are the weakest. Efforts at job placement are handled by the voluntary rehabilitation agencies, the commercial and trade schools to whom DVR clients are sent and who, according to DVR personnel, have excellent placement services. Other major placement is done by the New York State Employment Service and directly by DVR rehabilitation counselors.

The State Employment Service has a selective placement program. "For the last five years 27,000 to 33,000 disabled persons applied yearly to the Employment Service as new registrants for selective placement."[1] As an indication of the volume of services in New York City, the Division of Employment reports that 23,187 placements were made of handicapped persons in 1967. DVR, for the same year, referred 459 people to the Employment Service and 367 placements were made. For the same period, 40 referrals were made by VRS and 20 placements resulted from VRS (blind) referrals.[2]

---

[1] **Facts in Brief,** The State Education Department, Division of Vocational Rehabilitation, (Series 1, for the period ending 6/30/65), Albany, New York, January 1966

Under an interagency agreement between the State Department of Labor, Division of Employment and DVR, the Employment Service also makes referrals of disabled job applicants to DVR. The Employment Service does not keep a record of the number of referrals made to DVR, and that agency has released no statistics. Further, DVR has not provided data to indicate the effectiveness of their counselor placement services. Of the 8,900 persons rehabilitated by DVR in 1966, we do not know whether the client was placed directly by DVR, the State Employment Service, his own efforts, or by the rehabilitation facility or the trade school. Such data would be enlightening.

In addition, a comment is in order about the term "placement". In the case of the Employment Service, each time an applicant is hired is considered a placement. One applicant may have been placed on several jobs; thus we do not know exactly how many individuals are involved, nor do we know anything about the duration of the placements. This leads to a discussion of follow-up services. DVR considers a person "rehabilitated" who has been placed on a job and has been working for 30 days. His case may then be closed as rehabilitated. What his status is after 30 days, we do not know. There is a considerable flow of reapplications to DVR for further placement efforts, but there is no data available for analysis.

Some of the Task Group Reports have commented on this situation. The report of the Blind and Visually Handicapped recommends that follow-up should be extended and more attention devoted to determining the client's progress and status after rehabilitation services have been completed. Determination should be made as to whether optimum utilization has been made of such services. In this way there can be quantification as to whether or not services are meeting the needs of disabled persons. Similarly, a study should be made of the problems in job placements of disabled clients. The Report advocates extending follow-up in order to provide additional services to the client.

The Socio-Medical Report refers to "aggressive case-finding and follow-up". And, although it is not developed, it also offers the concept of "continual follow-up" in its construct of a theoretical model. This thread appears again in the Appendix to the Emotionally Handicapped Report where it is noted that, "For many clients, the aspect of chronicity must be dealt with." It advocates continued involvement of the client in group therapy and counseling. "This, too, would effectively help them over what some observers describe as "employment shock". As for placement activities, some of the reports advocate closer relations with the business community, including offering tax incentives to industry to hire disabled persons, as is done in some European countries.

43 THE STATE REHABILITATION AGENCIES, IN ESTABLISHING STANDARDS FOR REHABILITATION FACILITIES AND IN SUBMITTING THEIR PLAN FOR THE CONDUCT OF VOCATIONAL REHABILITATION SERVICES IN THE STATE, SHOULD PROVIDE FOR EXPANDED FOLLOW-UP AND PLACEMENT SERVICES THAT WOULD EVALUATE CLIENT STATUS AND PROVIDE SUCH ADDITIONAL SERVICES FOR THE CLIENT AS MAY BE NECESSARY.

Priority: Urgent Implementation Schedule: Short Term

44 THE STATE REHABILITATION AGENCIES SHOULD DETERMINE THE FEASIBILITY OF EXTENDING CLIENT FOLLOW-UP SERVICES FOR AT LEAST 6 MONTHS OR LONGER, AS THE CASE REQUIRES.

Priority: Urgent Implementation Schedule: Long Range

45 THE STATE REHABILITATION AGENCIES TOGETHER WITH UNION AND BUSINESS LEADERS AND THE VOLUNTARY AGENCIES SHOULD TAKE SUCH STEPS (INCLUDING THE DEVELOPMENT OF MODEL LEGISLATION) AS WILL ENCOURAGE INCREASED EMPLOYMENT OF THE HANDICAPPED BY THE BUSINESS AND COMMERCIAL WORLD.

Priority: Urgent Implementation Schedule: Interim

Recreation and Social Needs

Consistently, the Task Group Reports show a concern for the disabled that extends beyond the provision of training, medical treatment and rehabilitation facility experiences. The impact of this concern is to urge the vocational rehabilitation agencies to extend services not only to provide for recreation service, but to give attention to transportation needs, homebound programs, social and avocational services.

---

[1] *Op. Cit.* Fenton and Thompson, p. 100

[2] Communication to New York City Regional Office for Statewide Planning for Vocational Rehabilitation from Anne H. Altman, Director of Selective Placement, Division of Employment, October 4, 1968

Truly comprehensive services for handicapped persons should include some provision for social services as well. Those whose vocational future is limited by social obstacles, complex family and personal problems require resolution at the same time that traditional rehabilitation services are given. The Task Group for Respiratory Handicaps advocates provision of vocational rehabilitation services for those with severe personal problems that present a substantial handicap to employment.

The Trauma Task Group suggests aid to voluntary agencies who have programs which "foster independent living supports for those who are not DVR clients, but who are disabled." Recreational, avocational and social supports could be provided by voluntary rehabilitation agencies, if there were financial incentives to do so.

46 IN EXPANDING SERVICES TO THE DISABLED, PROGRAMS OFFERING RECREATIONAL, SOCIAL, AND AVOCATIONAL SERVICES SHOULD BE AUTHORIZED. VOLUNTARY AGENCIES OFFERING SUCH SERVICES SHOULD RECEIVE FINANCIAL AID FOR INCLUDING SUCH SERVICES AS PART OF COMPREHENSIVE REHABILITATION SERVICES.

Priority: Urgent Implementation Schedule: Interim

Services to the Homebound

We do not have any data that reveal the extent of the homebound population in New York City. Were there some central reporting service, this could perhaps be ascertained. There is, however, some material that suggests the value of augmented services to this group.

Facts in Brief of 1964-65 is of interest. Of the 8,505 persons rehabilitated during this period, 267 persons were homebound at the time their cases were accepted for service. At the closing of the case, only 88 persons remained homebound. This represents a net improvement in mobility of 67%. An additional 325 disabled individuals were capable of activity outside the home with the help of another person.

It is apparent from this information that vocational rehabilitation services for this group have had an effect in helping a large number of people to overcome being restricted to their homes.

Although we do not know how many more people are classed as homebound, several Task Group Reports considered the importance of expanding services to them. There was no indication of what these services might be. A few reports expressed concern for this group and seemed to identify the homebound person with the older person. As the Arthritis Report states, "Service to the homebound presently is provided on a limited scale, and few voluntary agencies do so; many more people could benefit from increased service in this area." A most specific service possibility comes from the Arthritis Report. It recommends that private agencies could enlist volunteers in working with the homebound, and these volunteers may be provided with insurance benefits, or related protection.

A related approach is offered that also demonstrates the extent to which the Task Group Reports feel comprehensive services should be given, and suggests that for the chronically ill person, the rehabilitation agencies and voluntary agencies ought to develop homebound services that might include homemaker arrangements. It was also noted in the justification accompanying this recommendation, that DVR can pay for certain interior alterations to facilitate the use of household amenities. While the Task Group Report recognized the responsibility of the Department of Social Services and the health agencies, it nevertheless suggests that for those chronically ill persons who are DVR clients, some responsibility should be shared in providing housing as an alternative to chronic care institutions.

47 THE DIVISION OF VOCATIONAL REHABILITATION AND THE STATE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED SHOULD CONDUCT A STUDY IN COOPERATION WITH VOLUNTARY AGENCIES THAT WOULD DETERMINE THE NUMBER OF HOMEBOUND PERSONS AND OPTIMAL SERVICES THAT SHOULD BE PROVIDED TO THEM.

Priority: Urgent Implementation Schedule: Interim

48 THE STATE REHABILITATION AGENCIES SHOULD SEEK LEGISLATION, ADOPT POLICY OR ENTER INTO JOINT AGENCY AGREEMENTS THAT WOULD EXPAND SERVICES TO THE HOMEBOUND. IT SHOULD ALSO UNDERTAKE JOINT COST-SHARING WITH PARTICIPATING AGENCIES.

Priority: Essential Implementation Schedule: Short Term

49 **THE DIVISION OF VOCATIONAL REHABILITATION AND THE VOLUNTARY REHABILITATION AGENCIES, IN THE EXPANSION OF SERVICES TO THE HOMEBOUND, SHOULD ENCOURAGE THE USE OF VOLUNTEERS.**

Priority: Urgent   Implementation Schedule: Interim

50 **THE STATE REHABILITATION AGENCIES, VOLUNTARY AGENCIES, AND OTHER GROUPS SHOULD SPONSOR LEGISLATION, IF NEEDED, TO PROVIDE SUBSIDIZATION TO MEDICAL REHABILITATION AND VOLUNTARY REHABILITATION AGENCIES WHO MEET STANDARDS HEREAFTER TO BE ADOPTED, FOR THE TRANSPORTATION COSTS INCURRED BY AGENCY PERSONNEL TRAVELING TO A HOMEBOUND CLIENT'S RESIDENCE.**

Priority: Urgent   Implementation Schedule: Short Term

Removing Architectural Barriers

"A recent public opinion poll revealed that 64 percent of the American people had not thought enough about how the handicapped manage to get around in their communities to realize that a serious problem exists."[1] In its report, the National Commission on Architectural Barriers discusses the problems and suggests some solutions. Among the problems:

- The greatest single obstacle to employment for the handicapped is the physical design of the buildings and facilities they must use.
- The most common causes of inaccessibility are due entirely to failure to think of the needs of the handicapped at the design and planning stage.
- One out of ten persons has some disability which prevents him from using buildings designed only for the physically fit.

An estimate of the number of people in New York City who may be restricted in the use of many public and private buildings is offered[2]

Arthritis	118,173
Heart Disease	127,754
Deafness	17,566
Blindness	43,916
Paralysis	31,939
Musculo-skeletal impairments	121,367
Other diseases of bones and joints	28,745
Hypertension	47,908
Circulation Problems	30,342
	567,710

Added to this number are those who are temporarily disabled by accidents who could return to work or school sooner if buildings were designed for accessibility, and 1,000,000 people over 65 years of age.

As the report states, some progress has been made in recent years as a result of the efforts of local groups and the National Commission. Upon the development of architectural specifications issued by United States of America Standards Institute, there were some attempts to involve local communities in adopting them. Since the issuance of the standards, 44 states have taken some kind of formal or legal action requiring that public buildings be made accessible to the public. In New York State, however, legislation for the elimination of architectural barriers was introduced in 1968, but was vetoed by the Governor.

New York City, on the other hand, passed extensive legislation which became effective January 1, 1969. The Building Code of the City of New York amends the City Charter and the Administrative Code. The building codes go far toward the elimination of architectural barriers in both public and residential construction. For the most part, new buildings and major building rehabilitation will have to comply to the new codes, but the large number of old buildings are not affected.

A further problem is seen in the spread of responsibility among city departments in dealing with architectural problems. For instance, The Department of Buildings administers the Building Codes, but responsibility for ramped curbs on street corners, making city parks and playgrounds accessible for the handicapped, and structural changes in existing public buildings is vested in other city departments. In addition, the New York City Planning Commission is in a critically important position to influence architects and engineers in the design of public and private buildings. It also has a significant role in matters dealing with public transportation where architectural barriers abound. What is needed in the New York City Region is the formation of a group of interested people and agencies to study and publicize the key provisions of the new Building Code and from this develop a series of clearly defined objectives in order to obtain compliance.

---

[1] Design for All Americans, A report of the National Commission on Architectural Barriers to the Rehabilitation of the Handicapped, Department of Health, Education and Welfare, Rehabilitation Services Administration, Washington D.C., December 1967

[2] Based on Table V

Closely related to architectural barriers elimination is the availability of accessible housing for handicapped persons. The Arthritis Task Group report dealt with this problem, but, here too, a series of objectives should be framed that would involve more adequate housing opportunities for the handicapped and their families.

51 APPROPRIATE CITY, STATE, FEDERAL AND VOLUNTARY AGENCIES AND INTERESTED INDIVIDUALS SHOULD UNDERTAKE A REVIEW OF THE NEWLY EFFECTIVE BUILDING CODES OF THE CITY OF NEW YORK AND DEVELOP AN EXPLICIT PROGRAM WITH CLEARLY DEFINED OBJECTIVES WHICH STRIVE FOR COMPLIANCE WITH THE CODES.

Priority: Urgent Implementation Schedule: Interim

52 IN ANY ADVISORY COUNCIL OR GROUP APPOINTED FOR COMMUNITY PARTICIPATION IN VOCATIONAL REHABILITATION PLANNING, ARCHITECTS, ENGINEERS, REPRESENTATIVES OF THE CONSTRUCTION INDUSTRY, AND MEMBERS OF GOVERNMENT RESPONSIBLE FOR BUILDING DESIGN SHOULD BE INCLUDED.

Priority: Urgent Implementation Schedule: Interim

Transportation Needs

Among the most serious problems facing the handicapped person who has difficulty in ambulation, are those concerning transportation. The Task Group Reports have identified many of these, and they will be briefly outlines.

- Employed disabled persons incur heavy expense in traveling to and from work.
- Public transportation for amputees, cardiac cases, older persons, arthritics, orthopedically handicapped, and accident victims is frequently inaccessible and difficult to use because of inappropriate design. Subway entrances, bus loading and unloading platforms and doors present substantial difficulties.
- Inaccessible transportation for many handicapped people prevents their attending clinics, workshops, or even recreational or social events.
- There is also a need to provide for transportation costs of health professionals and voluntary agency personnel to homebound clients. Because of financial shortages, many of these services cannot be provided.

Of note is the actual service that the state rehabilitation agencies render to their clients. Transportation costs are met by the Division of Vocational Rehabilitation for many clients. From Federal sources, we are informed that New York State in 1967 provided transportation and maintenance services to 6,916 DVR clients, and 342 Commission for the Blind clients. The average cost per person for DVR was $250, and for the Commission $433.[1] These, of course are statewide figures and there is no separation of transportation costs or maintenance costs.

53 THE STATE REHABILITATION AGENCIES, VOLUNTARY AGENCIES, AND OTHER GROUPS SHOULD SUBMIT LEGISLATION ON STATE AND LOCAL LEVELS TO ACCOMPLISH THE FOLLOWING:

a. PROVISION OF FUNDING FOR SPECIAL TRANSPORTATION COSTS FOR CLIENTS ATTENDING MEDICAL REHABILITATION OR VOCATIONAL REHABILITATION FACILITIES OR PROGRAMS.

b. PROVIDE TAX DEDUCTIONS FOR THE EXTRA PERSONAL COSTS TO PHYSICALLY HANDICAPPED PERSONS TRAVELING TO AND FROM GAINFUL EMPLOYMENT.

Priority: Urgent Implementation Schedule: Short Term

---

[1] State Vocational Rehabilitation Agency Program Data, Administrative Service Series No. 68-16, Department of Health, Education and Welfare, Social and Rehabilitation Services, Washington, D.C., March 1968, pp. 13, 41

54 FURTHER PLANNING WITH APPROPRIATE OFFICIALS OF THE NEW YORK CITY GOVERNMENT IS REQUIRED IN ORDER TO SYSTEMATICALLY DEVELOP DESIGN CHANGES IN PUBLIC VEHICLES, SUBWAY ENTRANCES AND PLATFORMS, THAT SHALL ACCOMMODATE THE PHYSICALLY HANDICAPPED PERSON. A SPECIAL COMMISSION TO RECOMMEND IMPLEMENTATION SHOULD BE APPOINTED BY THE GOVERNOR OF THE STATE AND THE MAYOR OF THE CITY OF NEW YORK.

Priority: Urgent　　　　Implementation Schedule: Interim

PART II

ESTIMATES OF DISABILITY

DISABILITY RECOMMENDATIONS

ESTIMATES

Estimates of the Prevalence and Incidence of Handicapped Persons by Category

For this preliminary report, information is required that describes the method and results of estimating the potential number of people eligible and available for rehabilitation services. In addition, the projections of need for service are to be carried through 1975. Except for the projections of need for 1975, the requirements have been met. Table V lists estimates of chronic disability for the New York City area. Table VI gives the estimate of people eligible and needing rehabilitation services.

"Eligibility and availability for services" requires a comment. There has been no consideration of these two factors in developing these estimates. Service eligibility for vocational rehabilitation has a strong subjective determinant, as is suggested in some of the Task Group Reports. Availability for service is perhaps even more difficult to estimate. It is much easier to measure availability for employment by counting the number of unemployed persons who must report each week in order to qualify for unemployment insurance. Availability for work is contingent upon eligibility for benefits. There is no requirement that one must be available for vocational rehabilitation services in order to qualify for any one of a number of special insurance or disability benefit plans, although some thought might be given to such a requirement in the future. For the present it is not possible to estimate how many handicapped persons are available for vocational rehabilitation services.

Research for this project would have been simplified were there reliable and statistically acceptable raw data. The New York City Region has an abundance of data, some of it accessible, some of it in the form our project can use. But the pertinent material remains buried in office files. Written requests for information from the local Division of Vocational Rehabilitation Office were invariably referred to Albany, where they still remain. Other requests were returned "information not available".

The result of the inaccessibility of information about DVR's local operations is that for the most part estimates were used. Observations and "guestimates" (informed judgement) became substitutes for objective data which should have been readily available. Nor is DVR the only agency whose information system leaves much to be desired. Requests were made to other State and local government units for information on activity levels and other relevant data. In a few instances, these requests are still pending. In contrast, the Metropolitan Life Insurance Company, within ten days of receipt of a telephone call, provided a printout of incidence of selected disabilities for their New York State policy holders.

Another set of barriers to information retrieval is lack of uniformity of nomenclature within the rehabilitation field. The Task Groups almost uniformly stress this complaint and point to the need for some order or system. (Recommendations 3 and 4) For some disabilities, indices are available based on the National Health Survey, but there is some reluctance to use these estimates for specific disabilities. Population counts or surveys were recommended, but as the Arthritis Task Group states, "A survey made in New York would undoubtedly be more accurate, but it can be seriously questioned whether the greater degree of accuracy would justify the time, effort and money which would be needed."

Methodology

As indicated, the primary assignment to the Task Groups in reviewing incidence and prevalence date, was to project the number of disabled people who would require vocational rehabilitation services. Some of the Task Groups attempted projections and in doing so, qualified the results and pointed to the difficulties in obtaining basic data and the lack of uniformity in the treatment of data and in reporting.

For the specific methodologies used, the Task Group reports should be consulted. In doing so, it will be noted that some projections were detailed, some were based on National Health Survey indices, and in one report, Heart Disease, Cancer and Stroke, Physician Service Patterns and Illness Rates, by Helen H. Avnet was used. Some statistical data was furnished by Metropolitan New York Regional Medical Program. In the case of the disability summaries for Arthritis and Respiratory Handicaps, Regional Staff inserted some of the indices from the Avnet study for comparative purposes.

Task Group Reports with incidence data are: The Blind and Visually Handicapped, The Deaf and Speech Impaired, Heart Disease, Cancer and Stroke, The Mentally Retarded, The Socio-Medically Handicapped, Arthritis and Respiratory Handicaps. No attempt was made to utilize the Task Group data because it does not yield complete coverage for the entire range of categorical disability. There was one exception, that of the Socio-Medical Group where the estimate was accepted in the absence of other studies dealing with this specific entity. Pages 87 and 88 of that report explain the method used in obtaining the estimate. In this report it was estimated that almost 91,000 persons are in need of vocational rehabilitation services, based on the definition offered which gives equal weight to the presence of a chronic medical condition, not in itself contributing to loss of functional ability, but which, when combined with social factors, constitutes a substantial handicap to employment.

2

The estimates used for the New York City Region are based on the National Health Survey issued in May 1965. Selected chronic conditions are used, and in Table V, national percentages for each category are given. These percentages or indices were developed from survey data obtained during the period from July 1961 to June 1963.

The number of handicapped persons in New York City is derived from 1965 population estimates after applying the national percentage for each chronic condition. No attempt is made here to project these figures to 1970 or 1975, or to obtain similar estimates for each of New York City's five counties.

For New York City as a whole, 873,522 persons are limited in activity because of chronic medical conditions. Added to this figure is the Socio-Medically Handicapped population of 454,393 (including ages from 17 to 65). The total estimate of chronic disablement for New York City is 1,327,915 persons.

TABLE V

ESTIMATED AVERAGE NUMBER OF PERSONS AND PERCENT DISTRIBUTION OF PERSONS REPORTED AS LIMITED IN ACTIVITY, BY SELECTED CHRONIC CONDITIONS CAUSING LIMITATION

NEW YORK CITY - 1965

Selected Chronic Conditions	Percent Distribution[1]	Number In New York City[2] Region
1. Tuberculosis, all forms	0.8	6,388
2. Malignant neoplasms	1.1	8,783
3. Benign and unspecified neoplasms	1.1	8,783
4. Asthma-hay fever	5.0	39,923
5. Diabetes	2.4	19,163
6. Mental and nervous conditions	7.7	61,482
7. Heart conditions	16.0	127,754
8. Hypertension without heart involvement	6.0	47,908
9. Varicose veins	2.4	19,163
10. Hemorrhoids	1.3	10,380
11. Other conditions of circulatory system	3.8	30,342
12. Chronic sinusitis and bronchitis	2.7	21,559
13. Other conditions of respiratory system	2.1	16,768
14. Peptic ulcer	2.4	19,163
15. Hernia	2.7	21,559
16. Other conditions of digestive system	4.6	36,729
17. Conditions of genitourinary system	5.0	39,923
18. Arthritis and rheumatism	14.8	118,173
19. Other diseases of muscles, bones, and joints	3.6	28,745
20. Visual impairments	5.5	43,916
21. Hearing impairments	2.2	17,566
22. Paralysis, complete or partial	4.0	31,939
23. Impairments (except paralysis of back or spine)	7.5	59,885
24. Impairments (except paralysis and absence) of upper extremities and shoulders	1.5	11,977
25. Impairments (except paralysis and absence) of lower extremities and hips	6.2	49,505
Total		873,522

[1] Based on statistics as reported in "Chronic Conditions and Activity Limitation: United States, July 1961-June 1963," Vital and Health Statistics: Data from the National Health Survey, Series 10, No. 17

[2] New York City population estimates from Demographic Projections for New York State Counties, July 1, 1966, prepared by the Office of Planning Coordination

Estimates of Those in Need of Vocational Rehabilitation Services

It is recognized that in order to plan for expanded services a more precise measure of the number of people who require services is necessary. It is doubtful that a precise measure will ever be known. With so many variables in the gathering of data, in the population density, in the administrative scatter, the kind of information needed would be most difficult to obtain. Perhaps more important than the technical obstacles is the human one: the individual determines whether or not he wants a particular kind of service and motivational factors are of crucial importance.

Percentages are much more comfortable to work with, and so the estimate of need for vocational rehabilitation service will be based on percentage. Here too, there are reservations. A higher percentage of need can be created by more effective case-finding techniques, and this will pre-suppose an abundance of resources to adequately serve larger numbers of persons.

TABLE VI

ESTIMATE OF NUMBERS OF DISABLED PERSONS NEEDING VOCATIONAL REHABILITATION SERVICES IN NEW YORK CITY, BY PERCENT OF NEED

	Numbers by Percent				
Disability	100%	5%	10%	15%	20%
Chronic Disability	873,522	43,676	87,352	131,028	174,604
Socio-Medical	454,393	22,719	45,439	68,159	90,879
TOTAL	1,327,915	66,395	132,791	199,187	265,483

In fiscal 1965, New York State Division of Vocational Rehabilitation and the New York State Commission for the Blind and Visually Handicapped served 30,756 individuals. In 1967 they served 31,305. New York State placed 51st nationally when the states were ranked by percent increase of total caseload served in 1967 as compared to 1965. In 1965 it rehabilitated 9,067 persons, and in 1967 this number decreased 10 percent to 8,187.[1]

It is estimated that the New York City Division of Vocational Rehabilitation and Commission for the Blind (VRS) served a combined total of 20,000 in 1965. In comparing this level of service with Table V data for the chronically disabled, it is seen that slightly more than 2.5 percent of the estimated disabled population actually received vocational rehabilitation services.

In order to serve 5 percent of the chronically disabled and the socially disadvantaged by 1969, even assuming the population in need of services remains constant, service capacity would have to increase by more than two-thirds.

Again, a qualification is necessary. The State agencies, although predominant in the numbers of persons served, are not the only agencies delivering vocational rehabilitation services. Private organizations also serve non-DVR or VRS clients. However, the total number of clients receiving vocational rehabilitation by both public and private agencies is not known.

Conclusions

Based on National Health Survey indices, New York City has a chronically disabled population of 873,522 persons, as of 1965. Based on estimates, the total DVR-VRS caseload for 1965 was 20,000 clients. This amounted to slightly more than 2.5 percent of the chronically disabled population who actually received vocational rehabilitation services.

Those with Socio-Medical Handicaps number 454,393 as of 1965. Added to those who are chronically disabled by medical conditions, the New York City estimate of those with handicapping conditions amounts to 1,327,915 persons.

If there were an arbitrary decision to reach 5 percent of the handicapped population (66,395 persons), the capacity of the government agencies would have to increase by more than two-thirds.

---

[1] Op. Cit., State Vocational Rehabilitation Agency Program Data, p. 2

THE BLIND AND VISUALLY HANDICAPPED

Definitions and Estimates

Two disability groups are studied: those legally blind, and those with visualy impairments. Legal blindness is generally defined in the United States as visual acuity for distant vision of 20/200 or less in the better eye, with best correction; or visual acuity of more than 20/200 if the widest diameter of the field of vision subtends an angle no greater than 20 degrees. A measure of 20/200 visual acuity means that a person can see at a distance of no greater than 20 feet what a person with "normal" sight can see at 200 feet. By definition, the term blindness is not synonymous with total blindness. The partially sighted are defined as persons with a visual acuity greater than 20/200 but not greater than 20/70 in the better eye after correction. The visually impaired (as represented in Table I) are defined as having severe visual impairment when the degree of impairment in a person six years or older renders him unable to read ordinary newspaper print with glasses; or under six years of age, or who have never learned to read, reported as "blind in both eyes," or indicating no useful vision in either eye. Other degrees of visual impairment are described as visual difficulty in a person six years or older not severe enough to prevent him from reading ordinary newspaper print with glasses; or for persons under six years of age who have never learned to read because of reported trouble in seeing (or something equivalent) but not indicating loss of vision in both eyes.

The Task Group provided data on the estimated number of persons with visual impairment in need of rehabilitation, personal adjustment, and/or vocational rehabilitation for New York State by age groups. It did not refine its estimates for New York City. For the purposes of this summary, the following table is offered to estimate the New York City population with visual impairment. Gross data only is given, without age differentials. The calculation is done by dividing the New York State total figure by 50 percent, which is roughly that portion of the state population resident in New York City.

TABLE I

ESTIMATED NUMBER OF NON-INSTITUTIONALIZED PERSONS WITH VISUAL IMPAIRMENT IN NEED OF REHABILITATION, PERSONAL ADJUSTMENT AND/OR VOCATIONAL REHABILITATION

Year	New York State	New York City
1965	59,053 [1]	29,526
1970	63,408	31,407
1975	67,507	33,753

[1] Approximately two-thirds of this number are over 65 years of age. It is estimated that in 1965, 39,862 of the New York State total were in this age category.

Measures or Indices Table I figures are based on an estimate of 5.6 per 1000 with visual impairment. It is further estimated that 1.9 per 1000 population are within the legal definition of blindness and 3.7 per 1000 population have serious visual impairments, but not within the legal definition. Projected figures are based on anticipated growth in population, greater life expectancy of persons with diseases which may eventually lead to blindness.

Table I is an estimate. Table II contains "hard fact" figures of persons registered with the New York State Commission for the Blind and Visually Handicapped. Yet, a qualification about the Commission registry is in order. Commission staff is of the opinion that not every blind person is actually registered. The percentage of non-registrants is unknown, but it is felt to be sufficiently large to warrant concern. This is implied in the number on the register in September, 1967 (25,075) and the estimated number of blind in the State in 1967 (35,400).

Table I, dealing with the visually impaired given a gross estimate for 1965 of 29,522, with projected increases for 1970 and 1975. It is questionable whether all these persons need vocational rehabilitation services. As the report states, further surveys and research would be useful in determining percentages in the

Tables that are capable of receiving rehabilitation and training to return to the community and/or work.

TABLE II

PERSONS REGISTERED WITH THE NEW YORK STATE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED BY AGE AND RESIDENCE

SEPTEMBER 1, 1967

				AGE			
RESIDENCE	ALL AGES	0-9	10-20	21-45	46-59	60 & over	Unknown
New York State	25,075	612	2,358	3,830	4,173	13,344	758
New York City	12,053	252	978	1,924	2,301	6,288	310
Bronx	2,146	47	188	350	381	1,142	38
Kings	3,964	66	284	645	821	2,016	132
New York	3,315	49	183	484	613	1,894	92
Queens	2,137	28	186	372	426	1,083	42
Richmond	491	62	137	73	60	153	6

Even with improved diagnostic and evaluation services and expanded casefinding efforts, only a percentage would be found in need of services. The crux of the problem is what the percentage is. If it is 10%, then almost 3,200 would require services by 1970 and 3,400 in 1975. But due to the unavailability of DVR statistics on service levels for this group, we have no basis for comparison.

Two-thirds of the blind persons registered with the Commission for the Blind are over 50 years of age. (See Table II.) Further, two thirds of those with visual impairments are over 65 years of age. (See Table I.) While no concrete evidence is found in the Task Group report, the assumption is made, but based on agency policies, that the bulk of this population accepted for service in New York City fall within the age range of 10 to 45 years of age. Further, the report stresses the concern for expanding services to older persons, and suggests broadening eligibility requirements by not placing emphasis on vocational goals.

For the Blind group, it is shown that 12,053 persons are on the register and of this number, 2,000, or 17 percent, are receiving or awaiting service. However, the report estimates that in 1967 there were 35,400 blind in the State. Since half of this population are found in New York City, 17,700 would be a fair estimate of prevalence, and were they identified, perhaps an additional 1,000 persons would be found in need of vocational rehabilitation services. This figure is obtained by using the same proportion of those on the register against those getting or waiting for service (17%).

If it can be assumed that 17% of the blind can qualify for vocational rehabilitation services, then the following estimates of need are projected on the higher estimated incidence:

TABLE III

ESTIMATE OF THE NUMBER OF BLIND IN NEED OF VOCATIONAL REHABILITATION SERVICES IN NEW YORK CITY

Year	Estimated Number of Blind	Estimated Number in Need of Services
1967	17,700	3,009
1970	20,000	3,400
1975	26,000	4,402

The Extent of Services - VRS, DVR

All legally blind persons are provided vocational rehabilitation by the Vocational Rehabilitation Service of the New York State Commission for the Blind and Visually Handicapped. The Commission is within the New York State Department of Social Services. The Division of Vocational Rehabilitation, New York State Education Department, provides vocational rehabilitation services to those with handicapping visual problems.

In order to accommodate the number of persons on its waiting list, VRS has made arrangements to use voluntary agencies to do the intake and medical screening prior to referral to active status, thus expediting the acceptance of additional cases.

Appendix C of the report of the Region I Task Group Report on Sensory Handicaps (Blind and Visual) is a record of a clinical workshop held on September 19, 1967 for personnel of the New York City Region, Commission for the Blind and Visually Handicapped, Division of Vocational Rehabilitation and Office of Statewide Planning. A description of problems and recommendations for each of the five New York City counties was presented. Significantly, it was mentioned that 50 to 60 percent of New York City VRS clients are multiply handicapped and have severe secondary disabilities.

In order to accommodate more of its clients, VRS is attempting to place the blind in comprehensive rehabilitation agencies. In addition, a Bronx office of VRS was opened in 1968.

Among other needs identified by the workshop participants were shortages in professional and stenographic staff, the need for more terminal workshops for the multiply handicapped, the resistance of some of the integrated or comprehensive agencies to accepting blind clients, better utilization patterns of rehabilitation facilities, problems in serving the non-English speaking client, dealing with transportation problems, increased emphasis on placement of the blind in jobs, professional recruitment and use of technical non-professional staff.

DVR projections included planning for an integrated sheltered workshop in central Brooklyn which would be able to provide personal adjustment and evaluation services. It was also found that an integrated, comprehensive workshop was needed in the Bronx because many handicapped clients from the Bronx must travel to Manhattan for services. The need for a rehabilitation facility in Staten Island was also noted by DVR and VRS.

General recommendations were as follows:

1. Federal, State and City experts would be involved in planning for improved transportation facilities for the handicapped.
2. Further study of the possibilities of "job dilation" in order to recruit rehabilitation personnel is needed.
3. In order to meet projected needs to expand and increase services, use of technical or sub-professional persons rather than professional personnel should be explored.
4. Increased salaries and an active recruiting campaign within colleges would improve recruitment.
5. More intensive efforts at placement of the handicapped by all agencies must be stimulated.

Other Agencies' Services

Five major agencies serving the blind and visually impaired were identified:

Brooklyn Bureau of Social Service
Industrial Home for the Blind
Jewish Guild for the Blind
New York Association for the Blind
United Cerebral Palsy, Queens

Data is not included which gives the client capacity, the average daily attendance, number of VRS or DVR clients served. Appendix B of the report does give the range of services provided by each agency, utilization rate, or staffing patterns.

A more detailed and complete statement of these agencies is expected to be obtained through a study done by the DVR Bureau of Facilities Planning.

Needs for rehabilitation facilities were noted in Staten Island, a comprehensive facility in the Bronx, and an additional facility in central Brooklyn.

It was found that voluntary agencies restrict their services to persons within the legal definition of blindness, except on an emergency basis they do accept borderline cases. Some agencies, however, accept the visually impaired. There are many people with visual impairment who are reluctant to seek services from a facility which services "blind persons". It would be preferable for the public and voluntary agencies to be staffed and equipped to offer services to partially sighted persons, but there should be two separate programs.

B-1 A JOINT STUDY SPONSORED BY DVR AND CBVH SHOULD BE MADE TO DETERMINE THE FEASIBILITY OF THE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED OFFERING SERVICES TO BOTH BLIND, AND VISUALLY IMPAIRED NOT BLIND (BY DEFINITION) PERSONS.

Priority: Urgent Implementation Schedule: Interim

Based on the reaction to such a proposal within the vocational rehabilitation community, it was suggested that another goal of such a study would be to determine whether the Commission for the Blind and Visually Handicapped should become part of the Division of Vocational Rehabilitation.

Because of the similarities between both disabilities, there is a logic to unified services. It can eliminate fragmentation of service and some duplication of effort.

B-2 A COMMISSION FOR ALL REHABILITATION PROGRAMS SHOULD BE ESTABLISHED BY AN EXECUTIVE ORDER OF THE GOVERNOR THAT WOULD REVIEW THE NEED FOR ADMINISTRATIVE CHANGES AT THE DEPARTMENTAL LEVEL AND WHICH WOULD LEAD TO MORE COMPREHENSIVE SERVICES TO BLIND PERSONS. REPRESENTATION SHOULD BE FROM ALL MAJOR DISABILITY GROUPS.

Priority: Urgent Implementation Schedule: Interim

Planned central responsibility for serving clients should be clearly established with the elimination of the duality of roles in following the client's progress. Thought should be given to the individual's needs, both at the point of referral and in authorizing a program of services, avoiding a routinized approach to the client.

B-3 THE STATE REHABILITATION AGENCIES SHOULD AS A MATTER OF POLICY DEVELOP THE CONCEPT OF THE SERVICE CONTINUUM.

Priority: Urgent Implementation Schedule: Interim

There should be a continuum of service from childhood, adolescence and maturity involving educational systems and leading to and involving rehabilitation agencies. These services can be effected through clearly defined lines of authority and responsibility for each area of service and function.

Administrative Policy

B-4 TO IMPROVE CASE-FINDING, CBVH SHOULD UTILIZE ITS DISABILITY REGISTER FOR THE BLIND AND THE VISUALLY IMPAIRED, AND IT SHOULD BE COMPUTER PROGRAMMED. A SPECIFIC UNIT IN THE COMMISSION SHOULD BE RESPONSIBLE.

Priority: Essential Implementation Schedule: Short Term

Identification of disabled persons would enable systematic follow-up to determine the need for services and the kind of referral which may be indicated. It would facilitate planning for future service requirements.

B-5 THE STATE REHABILITATION AGENCY SHOULD UNDERTAKE A CORRECT POPULATION COUNT OF THE BLIND AND VISUALLY IMPAIRED INDIVIDUALS.

Priority: Essential Implementation Schedule: Short Term

An accurate register would provide agencies with the information needed to plan for program, staff and fiscal purposes.

B-6 STATE REHABILITATION AGENCIES SHOULD ESTABLISH A PUBLIC EDUCATION PROGRAM, IN COOPERATION WITH PRIVATE AGENCIES, THAT WOULD CORRECT ATTITUDES TOWARD BLIND PERSONS AND EDUCATE THE PUBLIC ABOUT THE VALUE OF REHABILITATION SERVICES.

Priority: Urgent   **Implementation Schedule:** Interim

Another role for a public education program would be to inform private agencies, and their staffs and others about the contents of legislation affecting the blind.

B-7 STATE REHABILITATION AGENCIES SHOULD ESTABLISH GENERALIZED PLANNING AS AN ON-GOING PROJECT WITH THE PARTICIPATION OF VOLUNTARY AGENCIES.

Priority: Urgent   **Implementation Schedule:** Interim

The need for shared planning is obvious. It would provide both effective inter-agency coordination of future program needs, and develop ways for improving service patterns.

B-8 STATE REHABILITATION AGENCIES AND PRIVATE AGENCIES SHOULD UNDERTAKE A THOROUGH STUDY OF CURRENT FEDERAL LEGISLATION TO DETERMINE LEGISLATIVE TRENDS, AND THE MOST EFFECTIVE METHODS OF IMPLEMENTATION OF LAWS.

Priority: Desirable   **Implementation Schedule:** Short Term

B-9 STATE REHABILITATION AGENCIES AND PRIVATE AGENCIES SERVING THE BLIND SHOULD UNDERTAKE A REVIEW OF RESEARCH NEEDS AND RESEARCH LITERATURE TO ASCERTAIN APPLICABILITY TO PROGRAMS, AND TO DEFINE OTHER RESEARCH NEEDS.

Priority: Desirable   **Implementation Schedule:** Short Term

The two recommendations above are related. Research needs and research results may have implications for legislation and programming. A study of legislation on the other hand, could provide possibilities for the future. Both recommendations could be administratively placed in a planning office. (See Recommendation B-19.)

Interagency Relationships

B-10 THE STATE REHABILITATION AGENCIES AND THE VOLUNTARY AGENCIES FROM WHOM THEY PURCHASE CASE SERVICES, SHOULD BEGIN A REVIEW OF ADMINISTRATIVE PROCEDURES WHICH WOULD LEAD TO REVISION OR MODIFICATION OF PRACTICES.

Priority: Urgent   **Implementation Schedule:** Interim

There is a need to simplify procedures and reduce the volume of paper work in order to utilize effectively the professional staff of the voluntary agencies.

B-11 THE STATE REHABILITATION AGENCIES SHOULD ADOPT A POLICY OF ENCOURAGING DEVELOPMENT OF AND GIVING FINANCIAL SUPPORT TO VOLUNTARY REHABILITATION AGENCIES WHO OFFER COMPREHENSIVE SERVICES FOR TOTAL REHABILITATION.

Priority: Urgent   **Implementation Schedule:** Interim

Many blind and visually handicapped persons have multiple disabilities which a comprehensive agency can accommodate because they usually can offer the skills of several professional disciplines within one physical setting. Blind and non-blind persons can benefit from such an interaction. Within a comprehensive center, more intensive programs of person adjustment and better opportunities for education and vocational training are needed.

B-12 STATE REHABILITATION AGENCIES SHOULD EXPAND THEIR FINANCIAL SUPPORT OF SPECIALIZED AGENCIES SERVING THE BLIND.

Priority: Urgent   **Implementation Schedule:** Interim

It is important to give recognition to the particular value and importance of agencies serving the blind because they perform a specific function in the rehabilitation of the blind client. It is a specialized service that prepares the client in both competitive and non-competitive skills by offering differentiated programs in sheltered workshops.

B-13 EVERY AGENCY SERVING BLIND PERSONS SHOULD HAVE A PROFESSIONAL RECRUITMENT PROGRAM AND FORMAL AFFILIATION WITH A SCHOOL OR INSTITUTION WHERE TRAINING IS OFFERED. THIS PROVISION COULD BE INCLUDED IN CRITERIA FOR AGENCY ACCREDITATION.

Priority: Desirable — Implementation Schedule: Short Term

The benefits derived would be more valuable work-study placements for students, and that through the interplay between academic personnel and professional practitioners, better programs for clients can be developed and techniques refined.

Accreditation Standards

B-14 THE STATE REHABILITATION AGENCIES SHOULD FORTHWITH ESTABLISH ACCREDITATION STANDARDS FOR REHABILITATION CENTERS THAT INCLUDE BOTH PROGRAM CONTENT AND PHYSICAL PLANT.

Priority: Urgent — Implementation Schedule: Interim

Because of some disparity in programs and services among rehabilitation facilities serving the blind and visually handicapped, it is advisable to develop minimum agency standards which would encourage comprehensive programs or specialized services in order to assure quality of services. Program standards should be written and provide for physical, social, emotional and vocational rehabilitation.

B-15 THE STATE REHABILITATION AGENCIES, IN ESTABLISHING STANDARDS FOR REHABILITATION FACILITIES, AND IN SUBMITTING THEIR OWN PLANS SETTING FORTH THE CONDUCT OF VOCATIONAL REHABILITATION SERVICES IN THE STATE OF NEW YORK, SHOULD PROVIDE FOR EXPANDED FOLLOW-UP AND PLACEMENT SERVICES THAT WOULD EVALUATE CLIENT STATUS AND PROVIDE ADDITIONAL SERVICES THAT MAY BE NECESSARY.

Priority: Urgent — Implementation Schedule: Interim

Follow-up services should be extended and more attention devoted to determining the client's progress and/or status after rehabilitation services have been completed. Determination should be made as to whether optimum utilization has been made of such services. In this way there can be quantification as to whether services are meeting the needs of blind people. Similarly, a study could be made of problems in job placements of disabled clients.

B-16 THE STATE REHABILITATION AGENCIES, IN ESTABLISHING ACCREDITATION STANDARDS, SHOULD FIX SERVICE AND STAFFING PATTERNS FOR REHABILITATION FACILITIES.

Priority: Urgent — Implementation Schedule: Interim

This recommendation follows B-15 in order to further specify the kind of program and professional staffing patterns that should be encouraged in order to render quality services. Thus, if an agency provides one of the services listed below, minimal staffing specialties are shown.

Service	Staff
MEDICAL - low vision aids clinic, audiometric services, etc.	Internist, Opthalmologist, Neurologist, Psychiatrist, Otologist
SOCIAL - Mobility, personal adjustment, recreation	Communications instructors; mobility trainers, recreational personnel
EMOTIONAL -	Psychiatrist, psychologist, caseworker, group workers, counselors
EDUCATIONAL TRAINING -	Education and vocational counselors
PLACEMENT IN BUSINESS, CONCESSION STANDS, SHELTERED WORKSHOPS OR WORK ACTIVITY CENTERS -	Placement Specialists

Program Needs

B-17 VOCATIONAL REHABILITATION SERVICES FOR YOUNGER CLIENTS SHOULD BE PROVIDED BY THE VOCATIONAL REHABILITATION AGENCIES AND WHERE OTHER GOVERNMENT DEPARTMENTS HAVE A RESPONSIBILITY FOR THEIR CLIENTS OR CHARGES, INTERAGENCY AGREEMENTS FOR COST-SHARING AND PROGRAM DEVELOPMENT SHOULD BE UNDERTAKEN.

Priority: Urgent — Implementation Schedule: Interim

Services for the young children and adolescents must be considered by the vocational rehabilitation agencies. Collaborative programs should be developed by the New York City Board of Education, VRS, and DVR so that children can be prepared to enter educational sequences at proper age levels. For example, it appears that adolescents are being taught personal adjustment which should have been mastered in earlier years. For adolescents, it is not always possible to obtain services. However, those who require it are served by VRS and DVR, but a study should be undertaken so that all persons in this age group who are in need of service, irrespective of whether they are seeking it, can be brought into applicable programs.

B-18 SERVICES FOR THOSE OVER 60 SHOULD BE MADE AVAILABLE UNDER THE VOCATIONAL REHABILITATION PROGRAM WHERE THE NEED FOR REHABILITATION EXISTS, BUT NOT NECESSARILY IN CONNECTION WITH A VOCATION.

Priority: Essential — Implementation Schedule: Short Term

Programs are needed to accommodate:

a) older people who need rehabilitation in mobility and self-management thus enabling a family member to return to work;

b) those who desire and are able to achieve integration into regular community programs;

c) useful utilization of leisure time;

d) extended long-term workshop enrollment;

e) sheltered workshop opportunities for remunerative purposes.

Further, it is noted that two-thirds of the visually impaired are over 65 years of age, and that two-thirds of the legally blind are over 50 years of age. Services for this population segment should be expanded and opportunities for joint service delivery with the State Office for Aging should be explored by the State Rehabilitation Agencies.

B-19 THE STATE REHABILITATION AGENCIES SHOULD EXPLORE THE NEED FOR SPECIFIC PROGRAMS AND SERVICES, DETERMINE HOW IMPLEMENTATION IS TO BE ACHIEVED, AND FIX A TIME TABLE FOR IMPLEMENTATION OF THE FOLLOWING:

a) Better diagnostic service, evaluative procedures, and preventive services;

b) Make services available as early as possible to clients, for both the prevention and treatment of blindness. In this respect, a follow-up service is needed for all persons starting at birth and continuing through school age, working age, retirement, and with cumulative reports properly maintained;

c) Design collaborative programs with the Board of Education for school age children in complementary areas;

d) Define programs that are meeting the needs of blind persons;

e) Develop in-service training programs for staff and professional growth;

f) Establish training facilities for clients interested in vending stand operations and other programs for occupational training and on-the-job training;

g) Develop appropriate services for the homebound.

Priority: Essential — Implementation Schedule: Interim

The substance of these program needs relates to the desirability of establishing a continuum of service from childhood, adolescence, and maturity involving rehabilitation agencies. These services can be effected through clearly defined lines of authority and responsibility for each area of service and function.

In order to develop a continuum of services, responsibility for maintaining cumulative client records should be fixed, and joint agreements with appropriate public and private agencies should be undertaken.

Manpower

B-20 THE STATE REHABILITATION AGENCIES SHOULD UNDERTAKE A STUDY WHICH WOULD REDEFINE JOB DUTIES OF PROFESSIONAL STAFF LEADING TO THE UTILIZATION OF INDIVIDUALS WITH LESS FORMAL PROFESSIONAL TRAINING.

Priority: Urgent Implementation Schedule: Interim

A recognition of the need for additional staff, since there is to be an increase in the number of blind persons to be served, requires a study that will determine how professional persons can best be utilized, and how those with less training could be taught to assume specific job duties.

B-21 THE STATE REHABILITATION AGENCIES SHOULD EXPAND RECRUITMENT OF PROFESSIONAL STAFF FROM SCHOOLS OF HIGHER EDUCATION.

Priority: Urgent Implementation Schedule: Interim

Scholarship or other incentives are provided under various federal and state programs. The Rehabilitation Agencies must undertake systematic recruitment efforts that will describe employment opportunities; further, there should be some incentive to schools of higher education to expand their facilities to accommodate more students.

B-22 STATE REHABILITATION AGENCIES AND VOLUNTARY AGENCIES SHOULD FIX SALARIES ON A LEVEL WITH CURRENT COMMUNITY TRENDS.

Priority: Urgent Implementation Schedule: Interim

Equitable salaries will aid in recruiting young people into the rehabilitation field, and may effect staff turnover.

Funding

B-23 THE STATE REHABILITATION AGENCIES SHOULD MAKE A CAREFUL EXAMINATION OF HOW THE PRESENT VOCATIONAL REHABILITATION SYSTEM WORKS BEFORE ALLOCATING FUNDS, ESPECIALLY FOR GRANTS OR SPECIAL PROGRAMS, ON A COST-BENEFIT BASIS.

Priority: Urgent Implementation Schedule: Interim

Increased funding is required from federal, state and city sources in order to accommodate persons needing service. But it is understood that needs for service will outstrip the funds necessary to provide them. It is necessary to avoid a duplication of public and private dollars in the provision of services. This requires a broad approach because vocational rehabilitation touches so many related disciplines and governmental and private agencies. Actually, this recommendation would require the state rehabilitation agencies to embark upon systematic financial programming based on system analysis.

AUDITORY-SPEECH DISABILITIES

Definitions and Estimates

The Auditory-Speech disability category is composed of widely different populations in regard to disability, handicap, and rehabilitation needs. In order to facilitate an evaluation of these populations the committee reviewed four groups which in themselves are highly divergent: the deaf, the hard of hearing, language disorders, and speech defects. These populations in total are twice the number of the next largest disability group.

There are at least six widely differing definitions of deafness in professional use today depending on the defining speciality. In this review, those whose hearing function is totally absent and who also have concomitant severe limitation of the voice, language, and speech function will be considered as deaf. Onset of disability is either at birth or early childhood. In terms of vocational rehabilitation planning, the committee limited its study to that segment of the hard of hearing population having binaural hearing impairments for whom habilitation and rehabilitation is most often needed.

Though it is not possible to adequately define these two groups, the committee has attempted to estimate the number of persons with hearing impairments using National Health Survey data.

TABLE I

DISTRIBUTION OF POPULATION BY SEX FOR NEW YORK CITY BASED ON 1960 CENSUS

Borough	Male	Female
Brooklyn	1,263,349	1,363,970
Bronx	681,696	743,119
Manhattan	801,779	896,502
Queens	862,643	946,935
Staten Island	109,970	112,201

TABLE II

NUMBER OF HEARING IMPAIRED PERSONS, MONAURAL AND BINAURAL, IN NEW YORK CITY BASED ON 1960 CENSUS WITH APPLICATION OF ESTIMATED PERCENTAGE FROM 1962-63 NATIONAL HEALTH STATISTICS, BY AGE GROUP AND SEX

	NUMBER OF HEARING IMPAIRED PERSONS		
Age Group	Males	Females	Total
Infant	6,480	6,297	12,777
Pre-school	8,894	8,631	17,525
Elementary School	15,214	15,876	31,090
Jr. High School	7,933	7,792	15,725
High School	7,937	7,079	15,016
Jr. College	5,667	6,732	12,399
20 - 24	10,154	11,891	22,045
17 - 44	62,528	69,935	132,463
45 - 64	43,250	48,763	92,013
65 plus	16,732	20,460	37,192

TABLE III

NUMBER OF HEARING IMPAIRED PERSONS WITH BINAURAL LOSS IN NEW YORK CITY BASED ON 1960 CENSUS WITH APPLICATION OF ESTIMATED PERCENTAGE FROM 1962-63 NATIONAL HEALTH STATISTICS, BY AGE GROUP AND SEX

	NUMBER OF HEARING IMPAIRED PERSONS		
Age Group	Male	Female	Total
1 - 2	3,318	3,224	6,542
Pre-School	4,554	4,430	8,984
Elementary	8,302	8,129	16,431
Jr. High School	4,062	3,990	8,052
High School	3,450	3,625	7,075
Jr. College	2,901	3,447	6,358
20 - 24	5,199	6,089	11,288
17 - 44	32,007	35,807	67,814
45 - 64	22,143	24,961	47,104
65 plus	6,256	10,475	16,731

TABLE IV

ESTIMATED TOTAL BINAURALLY IMPAIRED BY SEX IN NEW YORK CITY, BASED ON APPLIED PERCENTAGE OF 2.34 TO 1960 NEW YORK CITY CENSUS, WITH 1962-63 NATIONAL HEALTH STATISTICS DEAF PERCENTAGES

	Males	Females	Total
Binaurally hearing impaired	87,025	95,074	182,099
Deaf, included in above	18,190	19,870	38,060
"Hard of Hearing" is remaining number	68,835	75,204	144,039

Language Disorders The committee limited itself to a review of needs of language impaired children since little is know about the group as a whole. These children have been designated as having receptive and/or expressive language problems serious enough to warrant full-time educational placement for language development training. While etiology is more diffuse than specific, the following may be contributory to the degree and quality of the language impairments: central nervous system damage, peripheral impairment of auditory capacity, environmental factors and influences, and individual personality. There are presently 417 identified language impaired children in New York City.

Speech Disorders Speech disabilities have been considered symptomatically rather than etiologically, "Speech is defective when it deviates so far from speech of other people that it calls attention to itself, interferes with communication or causes its possessor to be maladjusted." (Individuals with speech disorders due to impaired hearing were omitted from this section.)

TABLE V

ESTIMATES OF THE PREVALENCE OF SPEECH DEFECTS IN THE 1966 POPULATION OF NEW YORK CITY, BASED ON AN ESTIMATED POPULATION OF 8,000,000 AND THE ESTIMATES OF THE 1950 WHITE HOUSE CONFERENCE

Type of Disorder	Estimated Prevalence (Figures rounded to nearest thousand)
General Incidence	480,000
Articulation	320,000
Stuttering	56,000
Voice Disorders	40,000
Retarded Speech Development	40,000
Speech Disorders due to Brain Injuries	16,000
Cleft-Palate Speech	8,000

Extent of Services

The New York City District of the Division of Vocational Rehabilitation serves all the populations in the auditory-speech disability category. During the 1966-67 fiscal year, DVR served approximately 800 deaf and many more hard-of-hearing clients. Two hundred deaf cases were closed after provision of services and over half of these clients were placed in employment. Deaf clients, on the average, remain on the agency's rolls from one to two years. However, many of the young people who are referred by schools for the deaf are served for much longer periods which may extend up to seven years when professional training is required.

All DVR client services are available and adapted to meet the special needs imposed by the audio-communicative disabilities. Counselors specifically trained to communicate with the deaf provide guidance and counseling services to such clients and their families. Other services - psychological, psychiatric and medical evaluation and treatment - are performed by specialized personnel. Professional training is sponsored at Gallaudet College for the Deaf in Washington, D.C. and will be sponsored at the National Technical Institute for the Deaf in Rochester. In addition, vocational, business, technical and professional training is sponsored in regular hearing schools with necessary supportive services.

The District Office uses both private and public agencies in New York City for these disability groups, and also is a referral source for these agencies. There are 125 speech and hearing centers in the Region, some of which receive state aid from the Department of Health. The evaluative and limited treatment services afforded by these centers are the only formal programs for language-impaired youth except for services offered at Public School 158 and a few special classes sponsored by the New York City Board of Education and St. Joseph's School for the Deaf.

Unlike the limited programs for the language impaired child, programs for the deaf and hard-of-hearing, adults and children, are offered by a greater variety of agencies. The New York City Board of Education provides for adult evening classes in communication skills. An itinerant teaching staff serves the school system, and there is a special school, Junior High School 47. The Lexington School, St. Joseph's School, St. Francis DeSales, and Yeshiva Institute are private facilities serving the deaf and hard-of-hearing population. During 1966-67, 1739 students (excluding adults) were enrolled in these programs. The New York City Board of Education also sponsors an infant auditory training program in hospitals and colleges for children from birth through five years of age.

Within the deaf adult group, almost 10,000 persons received some kind of service through the efforts of ten private voluntary and denominational agencies serving the deaf. Not all of these agencies provide a comprehensive program, but some provide a range of services. Among the services reported are religious instruction and special religious services, communication training, evaluation counseling (social, psychological and vocational), placement, and recreation. As an example, the New York Society for the Deaf has provided a vocational evaluation program specifically geared to the needs of the deaf as well as other rehabilitation services. The vocational evaluation program was developed in cooperation with DVR. The major agency serving the adult hard-of-hearing population is the New York League for the Hard of Hearing. The DVR Office also works with several State programs.

Specialized services for the deaf in Region I are provided by the New York Psychiatric Institute and Rockland State Hospital under the New York State Department of Mental Hygiene. The New York State Department of Health supports speech and hearing centers which provide complete diagnostic and limited therapy to children from 0-21 years. The New York State Employment Service offers job placement in all of its offices, one of which has a specially trained placement official. The New York State Education Department through the Bureau of Personnel Services offers direct service to some college bound hard-of-hearing boys and girls in the form of Readers Aid Service.

Finally, the DVR District Office refers clients in these disability populations to generic rehabilitation agencies. However, fuller utilization is deterred by the lack of professional personnel in these agencies specifically trained to deal with auditory-speech handicaps.

AS-1 IT IS RECOMMENDED THAT INTENSIVE STUDY OF THE VARIOUS STATE AGENCIES PROVIDING REHABILITATION SERVICES BE UNDERTAKEN TO HELP IN THE INTEGRATION OF THEIR OPERATIONS AND TO INSURE MORE EFFECTIVE COOPERATION BETWEEN THEM.

Priority: Urgent — Implementation Schedule: Interim

A number of State Divisions are involved in the habilitation and rehabilitation of the populations of the committee's concern. Such a study would enable these departments to shed the hampering rigidities and attitudes created by customs, tradition, and laggard legislation, and help them to integrate their operations and cooperate more effectively with one another as well as with local communities.

AS-2 THE DIVISION OF VOCATIONAL REHABILITATION SHOULD ESTABLISH STANDING COMMITTEES OF AUTHORITIES REPRESENTING SPECIFIC DISABILITY AREAS AND INCLUDING DIRECTORS OF FACILITIES, TRAINING PROGRAMS AND RESEARCH PROJECTS TO WORK WITH THE STATE FOR CONTINUAL EVALUATION OF SERVICES, COORDINATION OF ACTIVITIES, FOLLOW-UP AND THE PREPARATION OF RECOMMENDATIONS PERTINENT TO THE IMPROVEMENT AND EXPANSION OF REHABILITATION ACTIVITIES.

Priority: Essential Implementation Schedule: Short Term

If new resources are to be sought for large scale financing of capital or operating programs, and coordinated regional planning by State and local agencies is to be implemented, it seems desirable that efforts be made to use resources which also provide professionally competent consultation in the designing and evaluation of programs.

AS-3 IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION WORK WITH FEDERAL AND VOLUNTARY AGENCIES AND OTHER SPECIALISTS TO REDEFINE THOSE GROUPS WHO COME UNDER THE GENERAL HEADING OF HEARING-IMPAIRED TO LEAD TO A FUNCTIONAL CLASSIFICATION SYSTEM THAT WILL BE IMPLEMENTED BY ALL PUBLIC AND PRIVATE AGENCIES OFFERING VOCATIONAL REHABILITATION.

Priority: Urgent Implementation Schedule: Short Term

Otolaryngologists, audiologists and educators in their search for precise nomenclature have found that a numerical score expressed in terms of percentage or average decibel loss and other similar systems have produced loose and untenable criteria for health, education and rehabilitation programs. For those defined as deaf under the decibel system, there still remains diversity in terms of principle attributes of impairment and disability among the population.

AS-4 IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION WITH THE COOPERATION OF LOCAL PUBLIC AND PRIVATE HEALTH AND REHABILITATION AGENCIES CONDUCT A CENSUS OF HEARING-IMPAIRED INDIVIDUALS WHICH WOULD INCLUDE A SYSTEMATIC COLLECTION OF DATA CONCERNING DEGREE OF DISABILITY AND REHABILITATION NEEDS.

Priority: Desirable Implementation Schedule: Long Range

AS-5 IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION WORK JOINTLY WITH PUBLIC AND PRIVATE AGENCIES TO DEVELOP AND ADOPT A UNIFORM RECORDING AND REPORTING SYSTEM DESIGNED FOR COMPUTERIZATION.

Priority: Urgent Implementation Schedule: Interim

Recommendations 3, 4 and 5 are interrelated. Basic to all planning is knowledge of the size and nature of the groups for which programs are designed A relationship exists between uniform nomenclature used to collect census data which will be utilized for consistent reporting and recording, and from which programming for future needs can be developed.

AS-6 IT IS RECOMMENDED THAT THE STATE CONTINUE AND EXPAND REGIONAL PROGRAM PLANNING WITH ADEQUATE STAFF AND BUDGET AND IN COOPERATION WITH OTHER PROFESSIONAL AND ACADEMIC GROUPS, AND VOLUNTARY AGENCIES.

Priority: Urgent Implementation Schedule: Interim

Facilities in New York City which cannot meet the needs of local residents are straining resources to serve other sections of the State. It is not proposed that anyone be denied service but that other jurisdictions share in the provision of services.

AS-7 IT IS RECOMMENDED THAT A SHIFT IN REHABILITATION PROCESSING FROM THE PRESENT "CASE APPROACH" TO A GENERAL ASSISTANCE PROGRAM FOR HANDICAPPED YOUTH BE IMPLEMENTED.

Priority: Essential Implementation Schedule: Short Term

The habilitation and rehabilitation of the language-impaired youth, for example, is basically an unexplored area. A general assistance program, i.e., allocation of lump sum grants to any program with a vocational rehabilitation objective should encourage greater innovativeness and diversification of services. The schools are ideal settings for such programs. One of the principle aims of the reporters is to indicate and emphasize the critical relationship between education and rehabilitation of the deaf, in particular, and to the total disability group under study.

AS-8 IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION SUPPORT AND ENCOURAGE RESEARCH IN ALL AREAS CONCERNING THE AUDITORY SPEECH DISABILITY GROUP -- PSYCHOLOGICAL ASSESSMENT, LANGUAGE DEVELOPMENT, SUB-CULTURE OF THE DEAF, VOCATIONAL DEVELOPMENT, EDUCATION, GENETICS, FAMILY, AND EFFECTS OF INSTITUTIONALIZATION.

Priority: Essential Implementation Schedule: Short Term

This listing of research needs in the vocational rehabilitation of the deaf and other sub-groups in the auditory/speech category shows how much there is to be learned before anyone can say we "know" these groups. The vocational trends of the future will be determined in great extent by the findings of the study areas suggested.

AS-9 IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION PROVIDE SPECIAL IN-SERVICE TRAINING TO ITS PERSONNEL ON THE PROBLEMS OF THE AUDITORY/SPEECH DISABILITIES.

Priority: Urgent Implementation Schedule: Interim

The untrained worker contributes more to the problems of the deaf than to his rehabilitation and is the greatest single factor responsible for the generally negative attitude of the deaf population to rehabilitation facilities, efforts, and services. Curricula for this special training should be developed by academic institutions and local schools for the deaf and language-impaired.

AS-10 IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION ENCOURAGE AND FINANCIALLY SUPPORT AGENCIES PROVIDING EVALUATION AND/OR TRAINING SERVICES TO ITS CLIENTS TO HIRE PERSONNEL WITH SPECIAL ORIENTATION TO THE PROBLEMS OF THE AUDITORY-SPEECH DISABILITIES.

Priority: Urgent Implementation Schedule: Interim

Ideally, differential services, facilities, and programs should be available to the deaf and hard-of-hearing community that "match" the attributes as well as the needs of the individual seeking help. For example the "exceptional" and "above average" intelligence groups might very easily use the regular community resources available to the hearing with some slight modification. In the experience of the committee, there are many such facilities that would open their doors to the deaf providing they were encouraged to do so and supplied with orientation and supportive assistance as required. In this connection, it is rather ironic to note that it is the deaf population at the lowest end of the attributes range for whom community resources designed for the non-deaf are routinely used in vocational training and sheltered workshop. It is this population above all for whom specifically designed programs and facilities are essential.

AS-11 IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION AND THE STATE HEALTH DEPARTMENT REVIEW FEE SCHEDULES AND REVISE THEM UPWARD OR DEVELOP ALTERNATE GENERAL ASSISTANCE METHODS OF FUNDING. (See Recommendation 7.)

Priority: Urgent Implementation Schedule: Short Term

At the present more funding is needed to pay for administrative and staff services. Rates of payments for speech and hearing center service for children are unrealistically low. Follow-up services are required, but financial support for staff time needed for follow-up is not provided.

Interagency Relations

AS-12 IT IS RECOMMENDED THAT STATE AGENCIES COOPERATIVELY SET STANDARDS OF SERVICES FOR PROGRAMS DESIGNED TO AID THE HEARING IMPAIRED.

Priority: Urgent Implementation Schedule: Interim

The coordination of agency activities and procedures would insure equally high level service from all agencies for all clients. Consider a difference in procedures between the speech and hearing center and Medicaid programs: New York State Health Department Hearing and Speech Clinics are required to provide complete audiological testing before a hearing aid is recommended for a child, but Medicaid does not require this essential service for the adults it serves.

AS-13 IT IS RECOMMENDED THAT AN INTERAGENCY COMMITTEE TO INCLUDE AMONG ITS MEMBERS THE DIVISION OF VOCATIONAL REHABILITATION AND THE NEW YORK CITY BOARD OF EDUCATION BE ESTABLISHED TO DEVELOP, COORDINATE, AND IMPLEMENT ALL FACETS OF EDUCATIONAL AND REHABILITATION PROGRAMS FOR THE HEARING, LANGUAGE AND SPEECH IMPAIRED.

Priority: Essential Implementation Schedule: Interim

The Committee should provide advice and consultation in:

1) Developing research leading to program development
2) Coordinating interdisciplinary exchange of information regarding the needs of the hearing, speech, and language impaired
3) Expanding the prevocational program at PS 158 with the consultation and financial support of DVR

The desired effect is for DVR to establish specific relations with New York City Board of Education and the various public and private schools for those with auditory-speech handicaps.

AS-14 IN VIEW OF THE FRAGMENTED APPROACHES TO SO MANY NEEDS, IT IS RECOMMENDED THAT STATE REHABILITATION AGENCIES ESTABLISH AND PUBLISH CRITERIA FOR THE EVALUATION OF PROPOSALS FOR NEW SERVICE PROGRAMS SUCH THAT THEY HAVE A PREVENTIVE ASPECT AND FIT INTO APPROPRIATE CONTINUUMS AND CONTEXTS OF SERVICES.

Priority: Urgent Implementation Schedule: Interim

The need for a service continuum is of utmost importance in the provision of rehabilitation. Agency fragmentation and administrative duplication have resulted in a discontinuous pattern with the result that both children and adults do not get a comprehensive range of service. Preventive programs which are in a strategic position for early case finding and referrals for service appear to be significantly undermanned. For some children little or no habilitation is available when initial assessment is completed. An assessment demands increase, therapy must be curtailed in some centers. For some, remediation must be based on inadequate assessment.

AS-15 IT IS RECOMMENDED THAT STATE AGENCIES ESTABLISH PROCEDURES FOR ACCREDITING FACILITIES DEALING WITH THOSE WHO HAVE AUDITORY-SPEECH DEFECTS. STANDARDS SHOULD BE SET REGARDING PROGRAM CONTENT, SCOPE OF SERVICES, AND QUALIFICATION OF PROFESSIONAL PERSONNEL.

Priority: Urgent Implementation Schedule: Interim

AS-16 IT IS RECOMMENDED THAT IN ESTABLISHING ACCREDITATION STANDARDS PROVISION BE MADE TO INCLUDE TRAINING PROGRAMS OFFERED BY QUALIFIED PERSONS IN ORDER TO PREPARE SPECIALISTS TO WORK WITH THE ADULT DEAF POPULATION.

Priority: Urgent Implementation Schedule: Interim

In effect the scope of service to the deaf community is drastically limited and ill-planned. Substantial improvement and expansion could be effected if planning were based on the differential attributes of the population served, its differential in-service needs and facilities, and the amount and kind of specialized professional expertise required in the programming and execution of services.

In this connection, it must be emphasized that no facility program is better than its manpower. The specially trained worker is a must. An accreditation procedure would include on-site inspection visits and publication of accredited facilities and professional training programs.

Program Needs

AS-17 IT IS RECOMMENDED THAT DIFFERENTIAL PLANNING REGARDING FACILITIES AND SERVICES BASED ON THE MAJOR NEEDS AND ATTRIBUTES OF THE PRINCIPAL SUBGROUPS WITHIN THE DEAF, HARD OF HEARING, LANGUAGE AND SPEECH IMPAIRMENT CATEGORIES BE ESTABLISHED BY THE STATE VOCATIONAL REHABILITATION AGENCY.

Priority: Urgent Implementation Schedule: Interim

There is great heterogeneity of disability and handicap among and within the groups comprising the auditory-speech handicapped population. This same heterogeneity presents different rehabilitation needs. It is possible, however, to stratify out a number of typical groups from the parent bodies. (The sub-committee on the deaf has done so for the adult deaf population). If the quality of rehabilitation services is to be sharpened and improved, services must be designed in accordance with needs.

AS-18 IT IS RECOMMENDED THAT A PUBLIC INFORMATION AND EDUCATION SERVICE BE ESTABLISHED IN THE DIVISION OF VOCATIONAL REHABILITATION.

Priority: Urgent Implementation Schedule: Interim

The survey should be designed to provide information on the distribution of deaf among facilities according to the type of service rendered and the services required in the future. Study of special schools for the deaf to identify ways of providing more effective preparation of pupils for the modern occupational world should be a major consideration. Identification of community resources that could be developed to fit into a broad program of services should be explored. The results of such a survey would provide a basis for differential program planning and result in the upgrading of non-integrated programs into a comprehensive service delivery system.

AS-20 IT IS RECOMMENDED THAT STATE AGENCIES USE PROFESSIONALLY COMPETENT CONSULTATION ON THE DESIGN AND EVALUATION OF NEW PROGRAMS. (See Recommendations 2 and 14 of this section.)

Priority: Urgent Implementation Schedule: Interim

AS-21 IT IS RECOMMENDED THAT A SPECIAL FULL-TIME GUIDANCE COUNSELOR BE PROVIDED BY THE NEW YORK CITY BOARD OF EDUCATION TO WORK WITH HEARING, LANGUAGE, AND SPEECH-IMPAIRED STUDENTS IN REGULAR HIGH SCHOOLS. FOR THOSE IMPAIRED YOUTH OF AGES 15-18 WHO ARE IN TERMINAL EDUCATIONAL PROGRAMS OR IN PREVOCATIONAL PROGRAMS, THE DIVISION OF VOCATIONAL REHABILITATION SHOULD AUGMENT COUNSELING SERVICES.

Priority: Urgent Implementation Schedule: Interim

The school is the most important rehabilitation facility for this disability group. Every effort should be made to integrate educational and vocational rehabilitation programs.

AS-22 IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION EXPAND ITS SERVICES TO OFFER A COMPLETE DIAGNOSTIC, REHABILITATION, AND SOCIAL SERVICE PROGRAM FOR THE ELDERLY HARD-OF-HEARING.

Priority: Essential Implementation Schedule: Short Term

The risk of hearing disability increases with age and the size of our older population is also increasing. There is at present an urgent unmet need for services for this segment of our population which must be met.

AS-23 IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION, THE NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE, AND NEW YORK CITY COMMUNITY MENTAL HEALTH BOARD PROVIDE INCREASED PSYCHIATRIC SERVICES FOR THE DEAF AND HARD OF HEARING.

Priority: Urgent Implementation Schedule: Interim

At the present time there are programs specifically providing these services to residents of Region I. They include Rockland State Hospital, The New York Psychiatric

Institute and a small program at Maimonides Hospital. It is not possible for these programs to serve all of the clients and their families in need of such services.

AS-24 IT IS RECOMMENDED THAT ALL AGENCIES DEALING WITH MANPOWER AND EMPLOYMENT SEARCH FOR SPECIFIC EMPLOYMENT AREAS — HIGH-LEVEL AND PROFESSIONAL INCLUDED — IN WHICH QUALIFIED HEARING HANDICAPPED INDIVIDUALS MAY BE EMPLOYED.

Priority: Urgent Implementation Schedule: Interim

The employment capabilities of these individuals are too often underestimated. They are downgraded by functional hearing loss only. These factors lead to unsatisfactory situations for the clients and a loss of valuable manpower for the community.

AS-25 THE DIVISION OF VOCATIONAL REHABILITATION SHOULD PROVIDE NECESSARY SERVICES TO FAMILIES OF THE AUDITORY-SPEECH IMPAIRED.

Priority: Urgent Implementation Schedule: Interim

Manpower

AS-26 IT IS RECOMMENDED THAT RECRUITING PROGRAMS BE EXTENDED INTO UNTAPPED AREAS AND INCLUDE THE CAREER LADDER CONCEPT.

Priority: Urgent Implementation Schedule: Interim

A recognition of the need for additional staff requires study of how those with less training could be taught to assume specific job duties. Any plan should include motivation and opportunity for advancement. In addition, emphasis should be placed on recruiting into the helping fields persons without professional training who can perform simple, meaningful, rewarding tasks in their own neighborhoods, Persons considered unemployable for service to people as home aides, baby sitters, "escorters," and drivers. This approach lends itself to an expanded program of family support services. Supervisory and consultant personnel in public and private facilities can combine efforts to provide training.

AS-27 IT IS RECOMMENDED THAT ALL STATE, CITY AND PRIVATE AGENCIES SPONSORING SERVICES TO THE HEARING IMPAIRED RECRUIT QUALIFIED HEARING HANDICAPPED PERSONNEL FOR THEIR PROGRAMS.

Priority: Essential Implementation Schedule: Interim

Wherever a choice is possible, deaf clients turn to the trained worker and especially to the trained worker who is himself deaf. In this connection, attention must be directed to the deaf community as an exceptional resource for rehabilitation manpower. The extraordinary contributions professionally trained deaf can make warrants all feasible modifications in "red tape" and other restrictive measures that keep such workers from enhancing the rehabilitation picture.

AS-28 IT IS RECOMMENDED THAT THE WIDE VARIATIONS IN SALARIES FOR SIMILAR LEVELS IN EACH PROFESSION BE REDUCED THROUGH PUBLIC-PRIVATE INTER-AGENCY STRUCTURING OF SALARY SCALES IN ANY GIVEN COMMUNITY.

Priority: Essential Implementation Schedule: Interim

AS-29 IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION UNDERTAKE ACTIVE RECRUITMENT DRIVES DESIGNED IN ACCORDANCE WITH INDUSTRIAL STRATEGIES AND COMBINED WITH PROFESSIONAL MOTIVATIONS.

Priority: Urgent Implementation Schedule: Interim

The recruiting of new personnel from all specialty fields on both a professional and paraprofessional level is a very necessary part of upgrading service to hearing-impaired persons. All inducements should be used to fill the demand for qualified personnel in private and public agencies. An organized recruitment approach is required concentrating on all likely sources of professional manpower such as universities, centers, clinics, and agencies, and employing all communication media such as brochures, flyers, television announcements, press releases and, particularly demonstration-lectures to arouse professional interest and public awareness including that of the employer-public.

AS-30 IT IS RECOMMENDED THAT THIS INTERDISCIPLINARY APPROACH BE EXTENDED AND EMPHASIZED THROUGH EDUCATIONAL CURRICULA, PROGRAMS OF PROFESSIONAL ASSOCIATIONS AND IN PRACTICE BY INTER-AGENCY EFFORT.

Priority: Essential Implementation Schedule: Interim

There are many specialties involved in the treatment and rehabilitation of the auditory-speech disability population. Each plays an integral role in the spectrum of services. Professional training and experience in all fields should prepare practitioners for intensive team work as well as for skills in their respective professions.

AS-31 IT IS RECOMMENDED THAT EXISTING INTERNSHIP AND GRANT PROGRAMS BE EXPANDED TO ENCOURAGE EXPERIENCED TEACHERS OF THE LANGUAGE IMPAIRED TO ENTER TRAINING IN REHABILITATION COUNSELING.

Priority: Urgent Implementation Schedule: Interim

Rehabilitation counselors in increasing numbers will be needed. They will require experience and insight into the area of language impairment and should be able to work with the schools when needed. On the other hand teachers with insight into the rehabilitation needs of older language impaired children are and will be needed. At least some of these teachers should have background in prevocational and vocational training.

AS-32 IT IS RECOMMENDED THAT A SURVEY OR PROFESSIONAL PERSONNEL SERVICING THE DEAF COMMUNITY BE CONDUCTED TO DETERMINE THE AMOUNT OF MANPOWER IN EACH OF THE "TEAM" SPECIALTIES REQUIRED FOR ADEQUATE SERVICE.

Priority: Essential Implementation Schedule: Short Term

All national and local surveys reveal the gap between population need and supply of trained workers in hearing rehabilitation, but the kinds and numbers of specialists required must still be determined to adequately plan for recruitment of personnel needed to improve and expand programs.

AS-33 THE DIVISION OF VOCATIONAL REHABILITATION SHOULD ESTABLISH CERTIFICATION CRITERIA AND PROCEDURES DESIGNATING PROFESSIONAL PERSONNEL QUALIFIED TO PRACTICE THEIR RESPECTIVE SPECIALTIES WITH THE DEAF. LISTS OF SUCH PERSONNEL SHOULD BE PUBLISHED.

Priority: Urgent Implementation Schedule: Interim

Certification criteria should include professional qualifications, special training or equivalent qualifications to serve the deaf in a given specialty, written exams, and clinical demonstration of proficiency.

Funding

AS-34 IT IS RECOMMENDED THAT FUNDING BE SECURED THROUGH THE ELEMENTARY AND SECONDARY EDUCATION ACT (TITLES I, II, IV), ECONOMIC OPPORTUNITY ACT, MANPOWER DEVELOPMENT TRAINING ACT AND THE VOCATIONAL EDUCATION ACT OF 1963 FOR DEVELOPMENT OF REHABILITATION-RELATED PROGRAMS FOR LANGUAGE IMPAIRED YOUTH UNDER SCHOOL AND AGENCY SPONSORSHIP.

Priority: Urgent Implementation Schedule: Interim

AS-35 IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION PROVIDE FUNDS UNDER THE VOCATIONAL REHABILITATION ACT (PL 89-333) AND THE NEW YORK STATE REHABILITATION WORKSHOP SUPPORT PROGRAM TO SUPPORT INNOVATIONS PROJECTS, SPECIALIZED PROFESSIONAL STAFF AND GENERAL REHABILITATION FACILITIES AND WORKSHOPS ORIENTED TO THE NEEDS OF THE AUDITORY-SPEECH HANDICAPPED POPULATION.

Priority: Urgent Implementation Schedule: Interim

The special and urgent needs of this disability population require that all sources of funding be tapped for the development of programs and services and recruitment of personnel.

HEART DISEASE, CANCER AND STROKE

Estimates

For estimates of the number of people with Heart Disease, Cancer and Stroke, some data is available, but to isolate the numbers with enough functional capacity to engage in a vocational rehabilitation program is most difficult. The Task Group Report contains three tables which present estimates and projections of the incidence of illness among the residents of New York City, by county for 1965, 1970, and 1975. While other statistics were included for heart disease and cancer, the projections based on the Avnet Study appear to be most reliable because they were based on medical insurance reports prepared by physicians.

TABLE I

SUMMARY OF INCIDENCE ESTIMATED RATES AND NUMBER OF PERSONS, BY DIAGNOSIS BASED ON ATTENDED ILLNESS AND PREVENTIVE CARE, NEW YORK CITY

Diagnosis[1]	Rate[2]	1965	1970	1975
Cancer	7.3	57,868	58,067	58,287
Stroke	.2	1,581	1,591	1,596
Diseases of Circulatory System	108.9	860,541	866,249	869,527
	TOTAL	919,990	925,907	929,410

Notes:

1/ Includes the diagnostic categories, "Diseases of the Circulatory System", "Malignant Neoplasms." Figures on Stroke are for those actually reported as such; total Stroke cases are much larger for they are reported under other diagnostic categories. Incidence for Heart cases is understated for the total of all cardiac involvements is not included.

2/ Rates per 1,000 exposure years are adjusted to the age-sex composition of the general population of the area and are based on the number of patients with any condition listed for a specified category.

Source:

Adapted by Office of Statewide Planning for Vocational Rehabilitation Service from: H.H. Avnet, Physician Service Patterns and Illness Rates, Group Health Insurance, Inc., New York, New York 1967.

Data on incidence shows that rates increase with age for these three broad categories of disease. This has implications for service eligibility of older persons.

The Avnet material indicates that "malignant neoplasm increased dramatically at age 55, doubling the rate found for the previous age interval."[1] At ages past 65, circulatory disease, among women particularly, was the leading diagnosis.

As previously stated, arriving at an estimate of need for vocational rehabilitation service is difficult to determine. An educated guess reveals the following:

---

[1] Op. cit., Avnet, p. 287

TABLE II

ESTIMATE OF NEED FOR VOCATIONAL REHABILITATION BY DISABILITY RATE, 1965

Diagnosis	Rate	Number of Persons
Cancer	33.%	19,000
Diseases of Circulatory System	10.%	86,050
Stroke	undetermined	

This data should be qualified, of course.[1] In actual determination of need for services, the Task Group Report states that adequate screening and evaluation are needed. From this, further refinements of actual need can be developed. The numbers given above, therefore, are primarily candidates of screening and evaluation for service. The 33% rate is based on five year survival rates. The 10% is a calculated guess.

Extent of Services

Specific information on the number of persons receiving vocational rehabilitation by public or private agencies is unavailable for these disabilities. Despite the lack of this information and considering the great incidence of disability within these categories, the number of people in New York City actually rehabilitated by the Division of Vocational Rehabilitation (an estimated 338 persons in 1964-65) was meager.

On the part of the public agency, the following explanations for service limitations were offered:

- Insufficient DVR staff and funds to render services
- Conservative medical direction unwilling to accept a high risk population for services
- Lack of precise eligibility criteria for catastrophic disabilities
- Lack of understanding by medical and hospital personnel of DVR services
- Long waiting period for DVR acceptance for service.

On the part of medical and health agencies, the following explanations for service limitations were offered:

- Inadequate procedures within hospitals for referring patients to medical rehabilitation units
- Absence of early referral for medical and vocational rehabilitation services
- Physicians in private practice uninformed about potentials of rehabilitation and fail to make referrals to either specialists or the vocational rehabilitation agency in any great numbers
- There is a reference gap between physicians, patients and facilities
- Medical students, internists, and residents are not reached by departments of rehabilitation in any significant way
- Lack of a service continuum that begins with identification of disability, medical evaluation of functional ability, and provision of services in the community which leads to independent functioning
- Inconsistent role differences within the medical profession
- Voluntary health agencies are uninformed about vocational rehabilitation services
- Private agencies also duplicate services and contribute to fragmented services in the care and treatment of the disabled. There is insufficient integration and coordination of services among them and much competition.
- There is an inadequate number of private rehabilitation agencies providing service to heart, cancer and stroke patients

---

[1] The report itself adequately expresses reservations about all estimates and on reporting of diseases.

HCS-1 BASED ON RESEARCH AND DEMONSTRATION, APPROPRIATE INDICES OF DISABILITY SHOULD BE DEVELOPED THAT WOULD HELP DETERMINE FOR EACH CATEGORY OF DISABILITY, THOSE WHO COULD BENEFIT FROM VOCATIONAL REHABILITATION. REGIONAL MEDICAL PROGRAMS AND THE NATIONAL INSTITUTES OF HEALTH COULD UNDERTAKE SUCH A PROJECT.

Priority: Essential — Implementation Schedule: Long Range

The need for a classification system to determine functional ability of those with various kinds of diseases, would assist in determining the kind and type of services that would be needed. Age, sex and education level should be included in such an index.

HCS-2 A STUDY SHOULD BE UNDERTAKEN BY HEALTH, HOSPITAL, WELFARE AND VOCATIONAL REHABILITATION DEPARTMENTS ON STATE AND CITY LEVELS TO DETERMINE WAYS IN WHICH A SERVICE CONTINUUM CAN BE DEVELOPED.

Priority: Urgent — Implementation Schedule: Interim

A service continuum would give systematic attention to physical, mental and socioeconomic problems at every step along the continuum. The gains made in treatment, or through the provision of related supports by other agencies, would be met by delegation of responsibility for specific functions. The absence of a service continuum that extends from doctor-hospital treatment to community-based rehabilitation services is indicative of the need to examine the relationships between other programs and systems.

HCS-3 A STUDY SHOULD BE UNDERTAKEN TO DETERMINE WHETHER VOCATIONAL REHABILITATION COULD BE ADMINISTERED INDEPENDENTLY OR IN A LARGER MORE EFFICIENT AGENCY, LIKE THE STATE HEALTH DEPARTMENT. SUCH A STUDY SHOULD BE CONDUCTED BY MANAGEMENT CONSULTANTS.

Priority: Urgent — Implementation Schedule: Short Term

Management consultants should be engaged to assist in formulating appropriate recommendations which would ultimately accomplish a fixing of responsibility, accountability, and integration of services to the disabled. The Task Group views rehabilitation broadly and is of the opinion that vocational rehabilitation should not be separately considered or administered. A rehabilitation agency can encourage the development of a service continuum. The Task Group feels that DVR might operate more effectively as part of the State Health Department because it considers vocational rehabilitation a vital and integrative element of health care.

Administrative Policy

HCS-4 THE DIVISION OF VOCATIONAL REHABILITATION SHOULD UNDERTAKE THE IMPLEMENTATION OF POLICY TO CERTIFY ALL VOCATIONAL REHABILITATION COUNSELORS AND PERMIT THEM TO WRITE REHABILITATION PLANS WITH SUPERVISION PROVIDED BY DVR. APPROPRIATE LEGISLATION SHOULD BE INTRODUCED BY THE STATE EDUCATION DEPARTMENT.

Priority: Urgent — Implementation Schedule: Interim

Certification would enable trained workers employed by hospitals and other agencies to assume responsibility for patient services. DVR intake problems would be lessened, and DVR caseloads would be lowered. Problems occasioned by the trend to longer in-service involvement would be shared by participating agencies.

HCS-5 THE DIVISION OF VOCATIONAL REHABILITATION SHOULD ESTABLISH A SET OF UNIFORM STANDARDS FOR REHABILITATION FACILITIES, INCLUDING HOSPITAL REHABILITATION UNITS. FINANCIAL INCENTIVES TO DO SO SHOULD BE PROVIDED BY AMENDMENTS TO THE VOCATIONAL REHABILITATION ACT, PUBLIC HEALTH LAWS, AND OTHER LEGISLATIVE PROVISIONS WHICH ALLOW FOR JOINT FUNDING.

Rehabilitation agencies and hospital rehabilitation units should have clear operating standards regarding the provision of services to the disabled. Once accredited as meeting standards, agencies would be authorized to employ certified workers to share responsibility for quality services. With adequate standards staff shortages in the health professions, service delays, and administrative duplication and fragmentation may be reduced.

HCS-6 THE DIVISION OF VOCATIONAL REHABILITATION SHOULD FORTHWITH ASSIGN A FULL-TIME MEDICAL DIRECTOR TO THE NEW YORK CITY OFFICE.

Priority: Urgent Implementation Schedule: Interim

Frequently, in cases accepted for service, there is a 30-day waiting period before approvals for case expenditures were authorized. Approval for these expenditures, as well as case acceptance for seriously disabled cancer and stroke patients is required. A full-time medical director, or the designation of a physician authorized to make these decisions, is justified in New York City because of the volume of cases.

HCS-7 THE DIVISION OF VOCATIONAL REHABILITATION SHOULD FORTHWITH DEVELOP BROADENED AND FLEXIBLE MEDICAL GUIDELINES GOVERNING THE KINDS OF CASES OF THOSE WITH CATASTROPHIC ILLNESSES WHICH SHALL BE ACCEPTED FOR SERVICES.

Priority: Urgent Implementation Schedule: Interim

For catastrophic illnesses such as cancer and stroke, the agency was found to be too conservative in its acceptances, even though it is admitted that each case must be individually reviewed. Service levels for those with the disabilities mentioned seem to reflect a reluctance to accept poor risks.

HCS-8 THE DIVISION OF VOCATIONAL REHABILITATION SHOULD EXPAND "OUT-STATIONING" OF VOCATIONAL REHABILITATION COUNSELORS IN HOSPITALS. DVR COUNSELORS SHOULD PARTICIPATE MORE DIRECTLY IN ORIENTING HOSPITAL PERSONNEL AS TO THE KINDS OF SERVICES PROVIDED BY DVR AS WELL AS TO FUNCTION ON HOSPITAL REHABILITATION TEAMS.

Priority: Urgent Implementation Schedule: Interim

The present policy of assigning DVR counselors to hospitals is worthwhile and should be encouraged. More hospitals should be reached. It is also recognized that DVR counselors are in an excellent position to educate and orient other hospital workers, and that an additional role would be to participate in team evaluation of patients who are hospitalized so that once the patient is discharged services are available to him without undue delay.

HCS-9 THE DIVISION OF VOCATIONAL REHABILITATION SHOULD FORTHWITH BEGIN TO PROVIDE A PUBLIC INFORMATION AND EDUCATION PROGRAM.

Priority: Urgent Implementation Schedule: Interim

It is necessary to inform industry and labor about the benefits accruing to society when the disabled are employed. Health care practitioners need to be informed about vocational rehabilitation services. Negative attitudes about the agency must be dispelled by a concerted public education program that informs both professional and prospective client.

HCS-10 THE DIVISION OF VOCATIONAL REHABILITATION SHOULD CONTINUE ON-GOING PLANNING FOR VOCATIONAL REHABILITATION OR REHABILITATION-RELATED SERVICES. THIS SHOULD BE DONE BY A CROSS SECTION OF SERVICE CONSUMERS AND THOSE WITH DIFFERENT PROFESSIONAL BACKGROUNDS.

Priority: Urgent Implementation Schedule: Interim

Many services and jointly operated programs have their origin in shared planning sessions. This should be formalized. Problems in various areas can be identified and resolved as a result of planning efforts. But the need to have information and review data must be supplied by a professional staff, for it is on this basis that decisions must be made.

HCS-11 THE DIVISION OF VOCATIONAL REHABILITATION POLICY SHOULD BE DEVELOPED REGARDING THE PROVISION OF VOCATIONAL REHABILITATION SERVICES FOR CHILDREN WHO HAVE HEART, CANCER OR CEREBRO-VASCULAR ACCIDENTS ON AN INTENSIVE BASIS STARTING AT JUNIOR HIGH SCHOOL LEVELS. IDENTIFICATION OF THESE YOUNGSTERS SHOULD BEGIN AT THE TIME OF ONSET, AND VOCATIONAL DIRECTION SHOULD BE UNDERTAKEN BY THE SCHOOL AUTHORITIES WHEN THE CHILD RETURNS TO CLASS. THIS REQUIRES DVR TO ENTER INTO A JOINT AGREEMENT WITH THE BOARD OF EDUCATION TO DETERMINE PROGRAM AND SERVICE NEEDS, INCLUDING COSTS AND STAFF NECESSARY TO IMPLEMENT SUCH A PROGRAM.

Priority: Essential Implementation Schedule: Short Term

HCS-12 YOUNG PEOPLE WITH ORGANIC HEART DISEASE, WHATEVER THEIR FUNCTIONAL OR THERAPEUTIC CLASSIFICATION AT THE TIME OF APPLICATION, SHOULD BE CONSIDERED AS HANDICAPPED AND THUS ELIGIBLE, UNDER LAW, FOR STATE REHABILITATION SERVICES. PROVISIONS TO INCLUDE SPECIFIC SERVICES FOR THIS AGE GROUP SHOULD BE INCLUDED IN THE STATE PLAN.

Priority: Essential   Implementation Schedule: Short Term

The recommendations above (11 and 12) have a common justification. The need to involve children at an early age in vocational goal setting is best accomplished by a school system engaged in teaching, and a vocational rehabilitation discipline that prepares young people for realistic employment based on functional ability. The school system and DVR, therefore, should determine exactly what services each of them would provide.

Inter-Agency Relations

Several recommendations relate directly to other private and public agencies, especially in the development of standards for rehabilitation facilities. No attempt will be made to duplicate these recommendations here, but what follows will further amplify some of the preceding recommendations.

HCS-13 THE DIVISION OF VOCATIONAL REHABILITATION, IN THE DEVELOPMENT OF STANDARDS AND REHABILITATION FACILITIES AND POLICY FOR THE CERTIFICATION OF REHABILITATION PERSONNEL, SHOULD DO SO IN CONJUNCTION WITH REPRESENTATIVE LEADERS FROM PUBLIC AND PRIVATE AGENCIES, BUSINESS, LABOR, CIVIC GROUPS, AND ACADEMIC AND PROFESSIONAL DISCIPLINES.

Priority: Urgent   Implementation Schedule: Interim

Involvement in setting standards for rehabilitation agencies must include those who provide the services: in fixing criteria for certification of personnel, academic and professional opinion is essential. To obtain balance, a broader participation from business, labor, and civic groups will prove beneficial.

HCS-14 WITH THE ACTIVE INVOLVEMENT, SUPPORT AND PARTICIPATION OF THE DIVISION OF VOCATIONAL REHABILITATION, VOLUNTARY AGENCIES SHOULD UNDERTAKE A JOINT-STUDY TO DETERMINE THE FEASIBILITY OF ESTABLISHING:

- WITH THE AID OF COMPUTERS, CENTRALIZED REFERRAL SERVICES FOR PATIENTS-CLIENTS, DOCTORS, RELATIVES
- CENTRALIZED INFORMATION ON FACILITY AVAILABILITY, SERVICE PROGRAMS, AND PROGRAM OPENINGS
- JOINT EDUCATIONAL AND FACT FINDING PROGRAMS
- REGIONAL PLANNING TO ELIMINATE GAPS AND DUPLICATION OF VOLUNTARY AGENCY SERVICES

Priority: Essential   Implementation Schedule: Long Range

A significant effort by the voluntary agencies should be made in the public and private sectors, each having common goals, to bring together closely related service deliveries. The profusion of service deliverers in this Region mitigates against closer integration and coordination of their services. The recommendations above would provide specific tasks of mutual benefit which would meet the needs of many agencies. DVR should provide much of the financial requirements necessary to implement task accomplishment.

Program Needs

HCS-15 IN THE ESTABLISHMENT OF STANDARDS FOR REHABILITATION FACILITIES IN HOSPITALS, PROVISION SHOULD BE MADE FOR PROPER EVALUATION OF EACH DISABLED PATIENT TO DETERMINE WHAT SPECIFIC REHABILITATION SERVICES ARE REQUIRED. CARE SHOULD BE TAKEN TO REQUIRE, BASED ON A PREDETERMINED INDEX OF FUNCTIONAL CAPACITY, THAT ALL PATIENTS FALLING WITHIN A SPECIFIED FUNCTIONAL CLASS BE REFERRED TO AN EVALUATION TEAM. (See Recommendations 1 and 7 in this section.)

Priority: Urgent   Implementation Schedule: Long Range

Screening and evaluation services would be essential in determining the patient's need for specialized attention and vocational rehabilitation. The fact that relatively few patients with the disabilities of concern are referred to medical rehabilitation departments has been noted. By fixing proper standards, more patients would be able to benefit. The team approach to evaluation of functional capacity is probably the most effective way to provide such evaluation.

HCS-16 AN INNOVATIVE PROGRAM SHOULD BE PROPOSED BY THE DIVISION OF VOCATIONAL REHABILITATION AND AN APPROPRIATE MEDICAL FACILITY THAT WOULD SERVE AS A DEMONSTRATION OF TEAM-ORIENTED CLINICAL SCREENING AND EVALUATION SERVICE WITH A DVR COUNSELOR ASSIGNED, OR A PERSON WHO WOULD OTHERWISE BE ELIGIBLE FOR EMPLOYMENT IN DVR AS A REHABILITATION COUNSELOR. THE PURPOSE WOULD BE TO FORMULATE SERVICE STANDARDS WITHIN MEDICAL FACILITIES USING RECOMMENDATIONS HCS-1, HCS-4, HCS-5, HCS-7, and HCS-15.

Priority: Urgent Implementation Schedule: Interim

Hospitals should play an expanded role in the rehabilitation process which continues after a patient has been discharged. Early preparation of the patient for vocational rehabilitation has been stressed. Hospitals should be encouraged to provide such services and to develop the optimal standards necessary for wider applicability. Support for the concept should be obtained from the State Health Department, the Hospital Review and Planning Council, and the New York City Health Services Administration. Joint program operation and financing could be arranged by DVR, Regional Medical Programs, and federal sources.

HCS-17 A STUDY SHOULD BE UNDERTAKEN BY THE DIVISION OF VOCATIONAL REHABILITATION TO COMPILE AN INVENTORY OF WORKSHOPS AND REHABILITATION FACILITIES PROVIDING A REHABILITATION SERVICE AND OF AGENCIES WHO OFFER A REHABILITATION-RELATED SERVICE. THIS SHOULD BE DONE BY BOROUGH OR CATCHMENT AREAS, OR CENSUS TRACT GROUPINGS. THE INVENTORY SHOULD INCLUDE THE NUMBERS OF CLIENTS SERVED, CAPACITY, AND THE RELATEDNESS OF THE AGENCY'S MAJOR FOCUS TO VOCATIONAL REHABILITATION.

Priority: Urgent Implementation Schedule: Long Range

Abundant facilities are available in many parts of New York City, but for the vocational rehabilitation community, there is no concise directory of agencies that answers the need to know what specialized or comprehensive services are available, how many clients are served or the kinds of disabilities served.

HCS-18 SIMILARLY, A STUDY SHOULD BE UNDERTAKEN BY THE DIVISION OF VOCATIONAL REHABILITATION TO DETERMINE THE NEED FOR MORE REHABILITATION WORKSHOPS FOR THOSE WITH HEART, CANCER, OR STROKE DISABILITIES. A DETERMINATION SHOULD BE MADE AS TO THE FEASIBILITY OF LONG-TERM WORKSHOP PLACEMENTS FOR SERIOUSLY DISFIGURED CANCER CASES AND AMPUTEES.

Priority: Urgent Implementation Schedule: Interim

The Task Group report notes that there is an inadequate number of private rehabilitation agencies providing service to heart, cancer and stroke patients. In view of the extremely high incidence of these disabilities, further study is needed to determine how many more workshops or rehabilitation facilities are required.

HCS-19 THE DIVISION OF VOCATIONAL REHABILITATION SHOULD PREPARE LEGISLATION FOR THE AMENDMENT OF THE STATE EDUCATION LAW IN ORDER TO AUTHORIZE DVR TO PROVIDE RECREATIONAL SERVICES FOR ITS CLIENTS.

Priority: Desirable Implementation Schedule: Long Range

Many patients have multiple handicaps, all of them have social problems. This combination, coupled with long-term aspects of chronic disability, require a range of services not presently provided by DVR. Recreational and social rehabilitation needs ought to be provided for by DVR.

HCS-20 CURRENT FEDERAL LEGISLATION PROVIDES FOR STATE PLANS TO MAKE PROVISION FOR SERVICE TO MEMBERS OF A CLIENT'S FAMILY WHEN A CLIENT IS ACCEPTED FOR SERVICES WITHIN THE VOCATIONAL EVALUATION AND WORK ADJUSTMENT PROGRAM. THE DIVISION OF VOCATIONAL REHABILITATION, IN DEVELOPING GUIDELINES FOR PROVISION OF SERVICES TO OTHER FAMILY MEMBERS, SHOULD AUTHORIZE

THE PURCHASE OF SUCH SERVICES FROM COMPETENT AGENCIES.

Priority: Urgent Implementation Schedule: Interim

Enabling either private or public agencies to provide services to members of a client's family, would be advisable in view of current staff limitations within DVR. Similarly, the service needs identified in Recommendation HCS-19 could be purchased by DVR from competent agencies.

HCS-21 THE DIVISION OF VOCATIONAL REHABILITATION SHOULD UNDERTAKE A STUDY TO DEFINE AND IDENTIFY TRANSPORTATION PROBLEMS FACED BY THOSE WITH SEVERE DISABILITY. VOLUNTARY REHABILITATION AGENCIES SHOULD PARTICIPATE IN SUCH A STUDY WHICH SHOULD RESULT IN FEDERAL OR STATE LEGISLATION TO PROVIDE FOR IMPLEMENTATION OF STUDY RESULTS.

Priority: Urgent Implementation Schedule: Interim

Amputees, stroke patients, and some cardiacs have great difficulty in using public transportation facilities. In addition, those employed have to use special transportation carriers at added expense. Federal legislation in this area is needed.

EMOTIONALLY HANDICAPPED

Estimates

It is estimated that between 25,000 and 37,500 persons in or from mental hospitals require service. However, only between 1,000 and 2,000 persons are receiving this service.

Examination of DVR Services

1. More DVR services are needed. The counselors function too closely within diagnostic categories, although 1965 Legislation offers a wider range and concept of those eligible for rehabilitation.
2. The DVR program should be decentralized according to population concentrations.
3. DVR counselors should be located in mental health centers and in comprehensive community rehabilitation centers.
4. Each DVR office should have an Employers Advisory Committee.
5. There should be vocational rehabilitation counseling for children as young as 8-10 years old.
6. Aged patients with functional skills should be accepted by DVR for job placement or referral to a workshop in order to earn a supplement to their Social Security.

Other Agencies

1. The Task Force was concerned that mental hospitals are developing rehabilitation programs limited to institutionalized population only.
2. Existing sheltered workshops and community facilities should be strengthened to increase services to the emotionally handicapped returning to the community.
3. There is need for long-term sheltered employment for those who cannot be expected to enter competitive employment.
4. There is need for grant support to provide on-the-job training, utilizing voluntary agencies.

Most Crucial Needs

Training

1. Career positions for vocational rehabilitation aides.
2. In-service training for teachers of the emotionally handicapped in the New York City schools.
3. Programs of teacher-training in special education, similar to the support program in social work training.

Education for Handicapped Children

1. Work-study programs for children in intermediate and secondary schools are needed.

Diagnosis and Identification

1. This is needed for children with emotional disturbances and mental retardation prior to school admission and in the early school years. Emphasis should be on a study of children rejected for kindergarten.

2. The evaluation services need expanding for functional capacity of those emotionally disturbed over 55 years of age.

Priorities for Implementation

1. Increase the volume of rehabilitation services.

2. Set up coordinated community-based rehabilitation programs.

3. Set guidelines so that the Division of Vocational Rehabilitation will adopt an expanded concept of rehabilitation.

4. Increase facilities for the education of the emotionally disturbed child.

5. Increase services for the aged who are chronically ill and emotionally handicapped.

6. Increase voluntary agency support.

EM-1 THAT COMMUNITY-BASED REHABILITATION CENTERS FOR PHYSICALLY DISABLED AND HANDICAPPED INDIVIDUALS PROVIDE SERVICES TO THE EMOTIONALLY HANDICAPPED. THE COMMUNITY REHABILITATION CENTER SHOULD SERVE A DESIGNATED POPULATION, HAVE DEFINED GEOGRAPHIC AREAS AND SERVE INDIVIDUALS OF ALL AGES.

Priority: Urgent — Implementation Schedule: Short Term

EM-2 THAT COORDINATION AND USE OF COMMUNITY AGENCIES ARE NECESSARY TO PROVIDE COMPREHENSIVE REHABILITATION SERVICES (SOCIAL, HOUSING, HEALTH, EDUCATION, ETC.) FOR THE EMOTIONALLY HANDICAPPED INDIVIDUAL WHO IS RETURNING TO HIS COMMUNITY.

Priority: Essential — Implementation Schedule: Short Term

EM-3 THAT THE VOCATIONAL REHABILITATION COUNSELOR OF THE NEW YORK STATE DIVISION OF VOCATIONAL REHABILITATION SHOULD BE INVOLVED FROM THE BEGINNING, IN PLANNING AND DEVELOPING PROGRAMS FOR INDIVIDUAL PATIENTS. WHILE DVR STAFF DOES PARTICIPATE IN HOSPITAL OR COMMUNITY FACILITIES BY DETERMINING CLIENT NEEDS, FURTHER "OUTSTATIONING" SHOULD BE EXPANDED.

Priority: Urgent — Implementation Schedule: Interim

EM-4 THAT HALFWAY HOUSES BE LOCATED IN NEIGHBORHOODS SO THAT RETURNING PATIENTS CAN BE SERVED IN A TRANSITIONAL PROGRAM. THESE PROGRAMS SHOULD BE SERVED BY THE DIVISION OF VOCATIONAL REHABILITATION COUNSELOR.

Priority: Essential — Implementation Schedule: Short Term

EM-5 THAT BROOKLYN WHICH HAS THE LARGEST POPULATION AND QUEENS WHICH IS THE SECOND LARGEST BE GIVEN PRIORITY CONSIDERATION FOR DECENTRALIZED SERVICES IN VOCATIONAL REHABILITATION.

Priority: Essential — Implementation Schedule: Interim

EM-6 THAT REHABILITATION FACILITIES AND SERVICES OF LARGE MENTAL HOSPITALS BE LOCATED AND PROGRAMMED TO INCLUDE INVOLVEMENT OF THE IMPAIRED INDIVIDUALS IN THE COMMUNITIES WHERE THEY ARE LOCATED. THIS MAY REQUIRE LEGISLATIVE CHANGES WHICH WOULD AUTHORIZE THE DEPARTMENT OF MENTAL HYGIENE TO PARTICIPATE IN FUNDING AND TREATMENT OF CLIENTS NOT TECHNICALLY UNDER THEIR CARE.

Priority: Urgent — Implementation Schedule: Short Term

EM-7 THAT THE NEW REHABILITATION FACILITY PLANNED FOR THE STATE MENTAL HOSPITALS SERVE THE COMMUNITY WHERE IT IS LOCATED AS A COMPREHENSIVE REHABILITATION CENTER, ACCEPTING ALL IMPAIRED INDIVIDUALS IN NEED OF REHABILITATION SERVICES. HERE TOO, LEGISLATIVE CHANGES ARE NEEDED WHICH WOULD PERMIT JOINT COST-SHARING AND OPERATION OF SUCH FACILITIES.

Priority: Urgent Implementation Schedule: Short Term

EM-8 THAT THE NEW YORK STATE DIVISION OF VOCATIONAL REHABILITATION ASSIGN A COUNSELOR TO THE REHABILITATION CENTER SO THAT VOCATIONAL REHABILITATION LEADING TO JOB PLACEMENT AND COORDINATED FOLLOW-UP CAN BE ACHIEVED. THE CURRENT AGREEMENT BETWEEN DVR AND THE DEPARTMENT OF MENTAL HYGIENE PROVIDES FOR THIS, BUT THE AGREEMENT SHOULD BE AUGMENTED TO PROVIDE FOR AN INCREASE IN DVR STAFF AND CONSULTATIVE SERVICES.

Priority: Urgent Implementation Schedule: Interim

EM-9 THAT CONSIDERATION BE GIVEN, UNDER THE REGIONAL HEALTH PLANNING COMMISSION, FOR THE ESTABLISHMENT OF A NEW BODY OR THE RESTRUCTURE OF THE EXISTING ONE TO INCLUDE PROBLEMS OF THE EMOTIONALLY HANDICAPPED AS PART OF THE PICTURE OF TOTAL REHABILITATION NEEDS AND TO BE A CENTRAL SOURCE OF INFORMATION.

Priority: Urgent Implementation Schedule: Interim

EM-10 THAT A STUDY BE DONE BY A CONSULTANT CORPORATION TO PRESENT THE POSITIVE AND NEGATIVE ASPECTS OF ESTABLISHING A DEPARTMENT OFFICE OF REHABILITATION.

Priority: Urgent Implementation Schedule: Interim

EM-11 THAT THE DIVISION OF VOCATIONAL REHABILITATION SERVICES BE DECENTRALIZED WITHIN NEW YORK CITY ACCORDING TO POPULATION CONCENTRATIONS.

Priority: Urgent Implementation Schedule: Interim

EM-12 THAT MORE EFFECTIVE WAYS OF PROVIDING REHABILITATION BE TESTED IN A COMMUNITY OR AREA IN NEW YORK CITY, USING RESEARCH FUNDS. (POSSIBLY AVAILABLE FROM COMPREHENSIVE HEALTH PLANNING AND TO A LIMITED EXTENT FROM THE REGIONAL MEDICAL PROGRAM.)

Priority: Essential Implementation Schedule: Interim

EM-13 THAT THE NEW CONCEPT OF REHABILITATION INCLUDE SERVICES FOR AMELIORATING SOCIAL AND ENVIRONMENTAL CONDITIONS THAT CONTRIBUTE TO IMPAIRED OR LIMITED FUNCTIONING.

Priority: Desirable Implementation Schedule: Long Range

EM-14 THAT A GRADED INSTITUTIONAL SHELTERED WORKSHOP BE RUN AS A DEMONSTRATION PROJECT TO DETERMINE ITS POSITIVE AND NEGATIVE FEATURES AND THE FUNCTIONING OF THE DVR COUNSELOR IN RELATION TO THE MENTAL HYGIENE COUNSELOR AND DEPARTMENT.

Priority: Desirable Implementation Schedule: Long Range

EM-15 THAT THE DIVISION OF VOCATIONAL REHABILITATION COUNSELORS BE LOCATED IN FACILITIES OUT OF THE INSTITUTION IN COMPREHENSIVE COMMUNITY REHABILITATION AND MENTAL HEALTH CENTERS TO ACT AS A LINK BETWEEN DEPARTMENTS AND TO FACILITATE THE RETURN OF THE EMOTIONALLY HANDICAPPED CLIENT TO THE COMMUNITY.

Priority: Urgent Implementation Schedule: Interim

EM-16 IT IS STRONGLY RECOMMENDED THAT EXISTING SHELTERED WORKSHOPS AND COMMUNITY FACILITIES AND SERVICES BE STRENGTHENED, EXPANDED AND UTILIZED TO SERVE THE EMOTIONALLY HANDICAPPED RETURNING TO THE COMMUNITY.

Priority: Urgent Implementation Schedule: Interim

EM-17 THAT EACH DIVISION OF VOCATIONAL REHABILITATION OFFICE HAVE AN EMPLOYERS ADVISORY COMMITTEE TO WORK WITH REGARDING EMPLOYMENT NEEDS OF THE AREA THEY SERVE.

Priority: Essential — Implementation Schedule: Interim

EM-18 THE DIVISION OF VOCATIONAL REHABILITATION IS URGED TO DEVELOP CAREER POSITIONS FOR VOCATIONAL REHABILITATION AIDES TO BE EMPLOYED IN COMPREHENSIVE COMMUNITY-BASED REHABILITATION FACILITIES IN ORDER TO RELIEVE THE CURRENT CRITICAL SHORTAGE OF REHABILITATION COUNSELORS.

Priority: Urgent — Implementation Schedule: Interim

EM-19 THAT THE DVR AND THE DIVISION OF PUPIL PERSONNEL SERVICES, BOTH OF WHICH ARE PARTS OF THE NEW YORK STATE DEPARTMENT OF EDUCATION, WORK TOGETHER TO INITIATE VOCATIONAL REHABILITATION COUNSELING AS EARLY AS 8-10 YEARS.

Priority: Urgent — Implementation Schedule: Interim

EM-20 THAT THE CHILD'S INTERMEDIATE AND SECONDARY EDUCATION INCLUDE EARLY PARTICIPATION IN WORK AT A LOCAL WORK-STUDY PROGRAM AND THAT CREDIT BE PROVIDED ON A SEMESTER BASIS FOR SUCH WORK COURSES. SUCH PROGRAMS MIGHT BE JOINTLY INITIATED BY THE NEW YORK CITY BOARD OF EDUCATION, THE DIVISION OF VOCATIONAL REHABILITATION, AND THE NEW YORK STATE DEPARTMENT OF EDUCATION'S BUREAU OF HANDICAPPED CHILDREN.

Priority: Urgent — Implementation Schedule: Interim

The problem of the chronically ill, emotionally handicapped person over 55 continues to grow. Inactivity and lack of purpose immobilizes many, resulting in premature dependence and, ofttimes, institutionalization for the remainder of life.

EM-21 EVALUATION BY A REHABILITATION TEAM OF FUNCTIONAL CAPACITY OF EACH EMOTIONALLY HANDICAPPED PERSON OVER 55 AND DETERMINATION OF REHABILITATION GOALS THAT WILL RETURN THE PATIENT TO THE FAMILY OR AN EXTENDED-CARE FACILITY NEAR HIS HOME.

Priority: Urgent — Implementation Schedule: Short Term

EM-22 REFERRAL OF SKILLED, AGED, CHRONICALLY ILL, FUNCTIONAL PATIENTS TO DVR FOR JOB PLACEMENT, OR REFERRAL TO A VOCATIONAL WORKSHOP TO EARN A SUPPLEMENT TO SOCIAL SECURITY.

Priority: Essential — Implementation Schedule: Short Term

EM-23 THAT GRANT APPLICATIONS RELATED TO ON-THE-JOB TRAINING UTILIZING VOLUNTARY AGENCIES BE GIVEN.

Priority: Urgent — Implementation Schedule: Interim

EM-24 THAT SUPERVISED HOME EMPLOYMENT LINKED TO A VOCATIONAL WORKSHOP BE CONSIDERED FOR THE EMOTIONALLY HANDICAPPED WHO CANNOT ENTER COMPETITIVE EMPLOYMENT.

Priority: Essential — Implementation Schedule: Long Range

EM-25 THAT LONG-TERM SHELTERED EMPLOYMENT FOR THOSE WHO CANNOT BE EXPECTED TO ENTER COMPETITIVE EMPLOYMENT, BUT WHO CAN BENEFIT FROM A SHELTERED AND PROTECTIVE MILIEU, BE ESTABLISHED IN EACH BOROUGH. SUCH EXTENDED CARE WORKSHOPS CAN BE PART OF COMPREHENSIVE REHABILITATION FACILITIES.

Priority: Urgent — Implementation Schedule: Interim

MENTAL RETARDATION

Estimates

The New York State Office of Planning Coordination estimated the total number of mentally retarded in New York City in 1965 as 117,500. Of this number, about 60,000 were in the age range 17 to 64 years. Projections of the prevalence in 1970 and 1975 yield approximately the same numbers. The Task Group stresses the necessity of including children in the totals for whom rehabilitation services are planned, which would thus increase the concerned population by about another 50,000 persons. Against these figures must be balanced the survey total by the Mayor's Committee on Mental Retardation which indicated that some 12,700 persons were receiving services from all community agencies in 1967, including the state schools for the retarded. Even if incomplete reporting were as great as 50 percent, the result is but one-fifth of the potential need. The Mayor's Committee survey reported only 876 persons in vocational rehabilitation programs.

Extent of DVR Services

There is no accurate count of the total number of mental retardates served by the New York City District Office of DVR in any one period. DVR estimates, however, that some 685 persons are served at any one time in some 15 community vocational rehabilitation agencies. The majority of these are under DVR auspices. The numbers of retardates who can be accommodated is pitifully small, even in terms of the 11,250 mildly retarded school population requiring special vocational rehabilitation services preparatory to entering competitive or sheltered employment.

Other Agencies

Voluntary vocational rehabilitation services are limited. Most are dependent on DVR fees, grants and subsidies. By and large, existing relationships are minimally effective in the sense that DVR utilizes all the community facilities for purchase of services for those clients it finds eligible and feasible. There are serious limitations, however, stemming from differing philosophical approaches, assumptions, conceptual bases and institutional biases.

Despite public education programs and an improving climate generally, the mentally retarded still rank low in any hierarchy where they are otherwise disabled. To a counselor who is responsible to administrative pressures for "successful rehabs," the mentally retarded applicant presents a challenge which may be viewed negatively. Counselor attitudes may be conveyed to private agencies in many forms: unrealistic expectations with respect to possible outcomes and the time required to produce these outcomes; criticism of agency programs based upon inadequate knowledge; ambivalent attitudes toward the client and agency, wanting on the one hand to "get rid of" the client, yet resenting the agency's "taking over" the client; difficulty in comprehending and dealing with the total life situation of the retardates--the pervasive effects of mental retardation, the client's dependence upon his family, the family's role in planning.

Most Crucial Needs

1. Removing requirements for "matching" money for receipt of public funds.
2. There is a vital need for early identification of the mentally retarded for whom there is presently no central registry.
3. The services required should provide for a continuum of treatment, adjustive media, and ongoing preparation and support of the retarded through adulthood.
4. There is a need for a coordinating body in the community to determine the needs of the retarded and the services required.
5. There is a very real need for more extended sheltered workshops.
6. There is a very real need for more clinical services for the retarded.
7. There should be provision for programs similar to Headstart projects to provide home-counseling to parents and children to ready them for entry into regular schools.

8. Although the availability of schooling for the retarded is mandated for ages 5 to 21, there are insufficient accommodations in the schools for these youngsters. DVR should become involved in planning with these retarded at the junior high school or first year high school level.

9. More retarded should be served in rehabilitation facilities which provide services to the multiple-handicapped.

10. There is a need for specially-trained caseworkers to work with the retarded and their parents to help them secure needed services.

11. Increased manpower not only among VR practitioners but in all disciplines serving the retarded is an urgent need.

MR-1 BECAUSE THERE APPEAR TO BE MORE MENTALLY RETARDED PERSONS IN NEED OF VOCATIONAL REHABILITATION SERVICES THAN ARE PRESENTLY BEING SERVED BY DVR, IT IS RECOMMENDED THAT INCREASED EMPHASIS BE PLACED UPON CASE-FINDING BY VOLUNTARY AGENCIES AS WELL AS BY THE SCHOOL SYSTEM.

Priority: Urgent Implementation Schedule: Interim

MR-2 BECAUSE APPLICANTS FOR VOCATIONAL REHABILITATION SERVICES ARE OBLIGED TO WAIT INORDINATE PERIODS OF TIME FOLLOWING APPLICATION, THERE IS NEED TO DETERMINE HOW MORE TIMELY SERVICES MAY BE FURNISHED, EITHER THROUGH ADMINISTRATIVE PROVISION AND/OR THROUGH INCREASED FUNDING TO PROVIDE THE MEANS FOR EXPEDITING SERVICES.

Priority: Urgent Implementation Schedule: Interim

MR-3 BECAUSE, REPORTEDLY, THERE IS AN UNEVEN UTILIZATION OF REHABILITATION FACILITIES, IT IS RECOMMENDED THAT STUDIES BE CONDUCTED BY THE DIVISION OF VOCATIONAL REHABILITATION, COMMUNITY ORGANIZATIONS, AND OTHER APPROPRIATE PERSONS TO DETERMINE AND ASSESS FACILITY UTILIZATION PATTERNS.

Priority: Urgent Implementation Schedule: Interim

Because of the uneven utilization of rehabilitation facilities, there may perhaps be a question as to the adequacy of such facilities for serving the needs of the retarded. To this effect, a study of their capacities, services, staffing equipment, and operating procedures is indicated. From this meaningful standards can be developed.

MR-4 BECAUSE THE MENTALLY RETARDED PRESENT PROBLEMS WHICH ARE CONSIDERED UNIQUE TO THIS DISABILITY GROUP, IT IS RECOMMENDED THAT DVR COUNSELORS WHO ARE ASSIGNED TO WORK WITH THEM BE REQUIRED TO PURSUE INTENSIVE IN-SERVICE TRAINING.

Priority: Urgent Implementation Schedule: Interim

MR-5 BECAUSE THE DIVISION OF VOCATIONAL REHABILITATION APPEARS UNABLE TO CARRY OUT ITS MANDATED RESPONSIBILITY FOR SERVING MORE DISABILITY GROUPS, IT IS RECOMMENDED THAT PROCEDURES BE DEVELOPED FOR ACCREDITING VOLUNTARY REHABILITATION FACILITIES IN THE COMMUNITY TO SERVE DVR'S CLIENTS MORE EXPEDITIOUSLY AND IN GREATER VOLUME.

Priority: Urgent Implementation Schedule: Interim

MR-6 IT IS FURTHER RECOMMENDED BY WAY OF IMPLEMENTATION THAT ADMINISTRATIVE ACTION OR, IF REQUIRED, ENABLING LEGISLATION BE ENACTED TO PROVIDE FOR THE FUNDING OF ACCREDITED FACILITIES FOR SERVING DVR CLIENTELE FROM INTAKE TO PLACEMENT AND FOLLOW-UP WITH DVR PARTICIPATION AND SUPERVISION.

Priority: Urgent Implementation Schedule: Interim

MR-7 BECAUSE WORKSHOPS AND REHABILITATION CENTERS SERVING THE MENTALLY RETARDED IN THIS COMMUNITY ARE OVERLAPPING IN THE POPULATIONS THEY ARE SERVING, IT IS RECOMMENDED THAT DVR CONDUCT A STUDY OF THE COMMUNITY AND TOGETHER WITH THE AGENCIES INVOLVED DETERMINE WHAT SPECIALIZATION IS NEEDED.

Priority: Urgent Implementation Schedule: Interim

MR-8 BECAUSE CRISIS-PLANNING AS PRESENTLY PRACTICED BY VIRTUE OF INADEQUATE FUNDING OR THROUGH LIMITED GRANTS IS A DISTINCT OBSTACLE TO THE DEVELOPMENT OF PROGRAMS FOR THE RETARDED, IT IS RECOMMENDED THAT ONGOING SUPPORT WITHOUT TIME AND FUND LIMITATIONS BE CONSIDERED.

Priority: Urgent Implementation Schedule: Short Term

MR-9 BECAUSE THE DIVISION OF VOCATIONAL REHABILITATION IN THIS COMMUNITY LACKS VISIBILITY, IT IS URGED THAT THERE BE PROVISION FOR GREATER ACCOUNTABILITY TO THE PUBLIC WITH REPRESENTATIVE PARTICIPATION OF THE COMMUNITY IN ITS PLANNING AND IN FIXING OBJECTIVES.

Priority: Urgent Implementation Schedule: Interim

MR-10 BECAUSE CITY-WIDE CENSUS DATA FOR THE B.C.R.M.D. AS OF 2/1/68 INDICATE THAT THE GREATEST ATTRITION OF EDUCABLE CHILDREN OCCURS AT THE JUNIOR HIGH SCHOOL LEVEL BECAUSE OF BEING OVERAGE, IT IS RECOMMENDED THAT DVR BECOME INVOLVED WITH THE MENTALLY RETARDED AT THE JUNIOR HIGH SCHOOL OR FIRST YEAR HIGH SCHOOL LEVEL IN ORDER TO SERVE THIS POPULATION.

Priority: Urgent Implementation Schedule: Interim

MR-11 BECAUSE A CLOSER WORKING RELATIONSHIP BETWEEN DVR AND B.C.R.M.D. IS INDICATED IN ORDER TO SERVE YOUNG PEOPLE WHO ARE NOT RECEIVING VOCATIONAL REHABILITATION SERVICES, IT IS RECOMMENDED THAT CONSIDERATION BE GIVEN THE CREATION OF A BOARD OF EDUCATION POSITION WHICH WOULD CALL FOR A REPRESENTATIVE OF B.C.R.M.D. TO BE ON THE PREMISE OF DVR TO CO-ORDINATE THEIR JOINT ACTIVITIES AND THEREBY TO SERVE MORE YOUNG CLIENTS.

Priority: Urgent Implementation Schedule: Interim

MR-12 BECAUSE MUCH OF THE TASK GROUP'S CONCERN IS FOR SCHOOL-AGED CHILDREN, IT IS ESSENTIAL TO EXPLORE THE ROLE OF THE NEW YORK STATE EDUCATION DEPARTMENT'S BUREAU FOR HANDICAPPED CHILDREN. SINCE THEY ALREADY PROVIDE CONSULTATION AND SUPERVISION TO THE NEW YORK CITY BOARD OF EDUCATION, THEY SHOULD INCREASE THEIR SERVICES AND FINANCIAL SUPPORT FOR SOCIAL, RECREATIONAL AND VOCATIONALLY-ORIENTED PROGRAMS.

Priority: Urgent Implementation Schedule: Interim

SOCIO-MEDICAL HANDICAPS

Incidence and Prevalence

Excluding persons under 17 and over 65 years of age, those with Socio-Medical Handicaps in New York City number 454,393 persons. This was obtained by using poverty indices for each borough developed by the Research and Planning Division of the New York City Community Mental Health Board and applying the indices to the adjusted population. This yielded the numbers identified as the "Poverty Population."

Based on an estimate developed from published literature, it was found that 35 percent of the population, or 454,393 persons, have Socio-Medical Handicaps.

Definition of Socio-Medical Handicap

"It is the existence of a physical, mental or emotional disability which is combined with social, educational, cultural or economic deprivation. In determining eligibility for vocational rehabilitation services, there should be certification of a chronic medical condition which need not limit a client's functional ability, but when combined with any of the deprivational aspects listed above, may cause a substantial handicap to employment."[1]

---

[1] Report of the Task Group on Socio-Medical Handicaps.

Estimate of Numbers in Need of Vocational Rehabilitation Services

The Task Group estimates that 20 percent of the Socio-Medically Handicapped population, or nearly 91,000 persons, need vocational rehabilitation services. This estimate too, is based on a review of literature describing a few select programs which made direct attempts to serve the poverty populations by outreach, casefinding, and services adapted to the needs of the deprived. Given more agressive attempts at outreach and advocacy, the estimated 20 percent in need of service is a minimal one.

Population Characteristics

Those with Socio-Medical Handicaps have a significant degree of medical pathology, not necessarily disabling, but when coupled with social, cultural, educational and environmental deficits, a substantial handicap to employment exists. Not included in this grouping were special populations such as the drug addict, juvenile delinquents or adult offenders, nor those under 17 or over 65.

In describing the characteristics of the Socio-Medical Handicap, note was taken of many social factors which contribute to social disability. The implication for those who would serve this group relates to the need to view the client realistically and within the context of his family life, his immediate environment, culture traits and educational experience. Motivation for this client group may be masked, but to reach them effectively, the professional worker may have to develop a new sensitivity and ability to communicate with people who have been labeled "hard to reach," "multi-problem," or "unmotivated."

Extent of Services

The following problems in concepts, service delivery and programs were noted.

- For those with a Socio-Medical Handicap, it was agreed that there is a high correlation between poverty and poor health, and if this is the case, then new service techniques would have to be developed to effectively reach and involve those whose deprivations constitute a disability.
- Rehabilitation includes medical, social, educational, and vocational elements.
- Assuming that disability is viewed as an individual's functional ability as influenced by his health and attendant medical, psychological, vocational, educational, cultural, social, or environmental factors, then it is essential that an uninterrupted service continuum be developed which is responsive to the total disability.
- Public and private agencies offer a multiplicity of services which may be either fragmented or coordinated, duplicated or restricted. Differing jurisdictions and eligibility requirements contribute to a discontinuous service continuum which adversely affects individuals in need of help.
- To accomplish integrated services, responsibility must be fixed. Legislative or administrative direction could do much to provide funding, policy guidelines, and other incentives so that strengthened services could be given.

At the present time, DVR service for the essentially deprived group is limited to a few programs undertaken cooperatively with the New York City Department of Social Services, a referral service with the New York City Board of Education's Manpower Development Training Program, and one outstationed DVR counselor with the South Bronx Concentrated Employment Program. In addition, the New York City Department of Social Service's Division of Employment and Rehabilitation presently has 1,500 public assistance clients active with DVR.

While the report recognized that DVR and VRS do serve a characteristically poor or financially dependent population, there is presently no extensive involvement with those who are socially deprived unless they have medically verified disabilities and meet current eligibility criteria.

What should be emphasized is that the programs listed above can develop expanded casefinding and outreach services. Those presently under care of DVR and VRS have been referred and found eligible. What the report advocates, and what is now included in the new Vocational Rehabilitation Act Amendments is the provision of services to an increased number of the disadvantaged under a special program of work evaluation and work adjustment (Title 15) leading to acceptance for traditional vocational rehabilitation centers or direct placement on a job.

In this regard, there is a need to reappraise the inventory of services for the disadvantaged in order to introduce vocational rehabilitation content into related programs. As a whole, rehabilitation programs for the Socio-Medical group have been minimal; therefore, a high priority is assigned to the development of the neighborhood center approach that would have elements of "outreach, referral and advocacy," with emphasis on evaluation and on-site diagnostic capability whenever possible. Of major importance is the need to provide adequate financial supports to clients enrolled in rehabilitation programs.

Several illustrations of neighborhood centers were discussed, each having a common element: the employment of aides or sub-professionals who would be part of a team approach in the delivery of services.

S-M 1 ESTABLISHMENT ON THE STATE LEVEL OF A DEPARTMENT OF REHABILITATION, OR A CENTRALIZED BUT INDEPENDENT OFFICE OF REHABILITATION.

Priority: Urgent Implementation Schedule: Interim

Six states already have organized rehabilitation services on a departmental level. In formulating final recommendations, the Regional Advisory Committee should suggest which administrative and service units ought to be under centralized jurisdiction.

One purpose of any restructuring is to design continuity and integration in the delivery of services which would cut across traditional service boundaries. There can be marked benefit for individuals and practitioners. Plagued with chronic shortages, professional staff can be better deployed; plagued with budgetary limitations, coordinated and integrated programs can protect the costs expended on those who have been hospitalized or institutionalized, or who have been dependent on public assistance, casework and educational agencies. Such a restructuring may not result in lower costs, but may provide the means to reach and serve more people.

S-M 2 FACILITIES ACCREDITATION AND PROFESSIONAL CERTIFICATION SHOULD BE UNDERTAKEN FORTHWITH BY THE DIVISION OF VOCATIONAL REHABILITATION.

Priority: Urgent Implementation Schedule: Interim

This process should be a joint undertaking of government and private agencies with representatives of professional groups and community leaders participating in the development of the necessary criteria. With such standards and accreditation, it would be possible to reduce waiting periods for service in DVR and uniform facility standards would insure quality services and yield effective facility utilization.

S-M 3 STATE AND MUNICIPAL CIVIL SERVICE DEPARTMENTS SHOULD DEVELOP CAREER LADDER CATEGORIES FOR PARAPROFESSIONAL OR TECHNICAL REHABILITATION PERSONNEL.

Priority: Essential Implementation Schedule: Interim

As a means of adding to the supply of rehabilitation manpower, the use of technician-aides is indicated. Careers in rehabilitation will require redefinition of current job titles and definition of new titles. This effort should be undertaken by professional, academic, and employer groups and by government personnel. Voluntary agencies should be encouraged to employ technician-aides, particularly if they apply for staffing grants. Appropriate in-service training or other educational (community-college) training should be developed with 100 percent of all costs paid by the federal government.

S-M 4 A NEIGHBORHOOD BASED MULTI-SERVICE CENTER NETWORK SHOULD BE DEVELOPED ON A PRIORITY BASIS.

Priority: Urgent Implementation Schedule: Short Term

At the present time the neighborhood multi-service center approach offers the best likelihood for prompt service delivery to the disadvantaged. Funding, staffing, administrative responsibility and community involvement are possible. A top-level coordinating group should be appointed forthwith to work out commitments for the establishment of at least one center in each borough except Staten Island. Such a group should have the support of the Governor, the Mayor of the City of New York, major federations of voluntary agencies, members of the legislature, and business and community leaders.

DVR liaison with the New York City Human Resources Administration and the Health Services Administration should be directed toward exploring opportunities for joint program operations, and integration of rehabilitation components into multi-service centers as afforded by the Housing and Urban Development Act of 1965 should be explored. Similarly, Neighborhood

Health Centers which provide ambulatory care should be considered as a prime source of referrals to rehabilitation programs.

Other municipal agencies offering rehabilitation services which require liaison and coordination are the New York City Board of Education, the Department of Correction, Department of Social Services, the Coordinator of Addiction Programs, and the Office of Probation.

4A CONSIDERATION SHOULD BE GIVEN TO THE EXTABLISHMENT OF CENTER SERVICES IN THOSE AREAS WITH A HIGH MAGNITUDE OF POVERTY. A SECOND PRIORITY FOR LOCATION OF SERVICES SHOULD BE IN TRANSITIONAL ZONES WHICH ARE AREAS WITH INCIPIENT DECAY.

Priority: Urgent | Implementation Schedule: Interim

4B JOINTLY OPERATED CENTERS SHOULD PROVIDE THOROUGH EVALUATION, SCREENING AND DIAGNOSTIC SERVICES. AS PREVIOUSLY SUGGESTED, INVOLVEMENT OF OTHER FAMILY MEMBERS IS DESIRABLE. THIS REINFORCES AN EFFECTIVE PROGRAM WHICH CAN REACH, HOLD AND INVOLVE THE HANDICAPPED.

Priority: Urgent | Implementation Schedule: Interim

S-M 5 BEGINNING IN FISCAL 1969-1970, ONE-HALF OF ALL FEDERAL GRANTS ALLOCABLE TO NEW YORK STATE UNDER THE VOCATIONAL REHABILITATION ACT, EXCEPT BASE PROGRAM FUNDS (UNDER SECTION 2 OF THE LAW), SHOULD BE ASSIGNED TO THE DEVELOPMENT OF THE MULTI-SERVICE CENTER APPROACH.

Priority: Essential | Implementation Schedule: Interim

In order to encourage the growth of the neighborhood concept as a means of delivering services to the disadvantaged, it is recommended that one-half of allocable funds available to the State of New York under the various grant catagories be made available for the implementation of neighborhood center services. An additional $5,000,000 to $6,000,000 should be allocated from Section 2 provisions.

Funds in 1969-1970 from various grant categories can approximate $2,000,000 to $3,000,000. Using the maximum figures from all sources, under the VRA Act about $9,000,000 in New York State could be devoted to establishing rehabilitation components in neighborhood centers. A minimum of 50 percent or $4,500,000 should be allocated to New York City.

Based on costs of $2,500,000 for four centers in New York City, $10,000,000 would be required. One-third to one-half of this sum could be available under Vocational Rehabilitation Act provisions. The remainder could be financed by state matching funds, grants, OEO, MDTA, Model Cities, or similar sources.

S-M 6 THOSE WITH SOCIO-MEDICAL HANDICAPS SHOULD BE SPECIFICALLY INCLUDED IN FEDERAL REGULATIONS AND BE MADE ELIGIBLE FOR VOCATIONAL REHABILITATION SERVICES. EXTENDED EVALUATION OR WORK ADJUSTMENT SERVICES SHOULD BE AVAILABLE FOR A PERIOD OF UP TO 18 MONTHS SO LONG AS THE CLIENT IS ENROLLED IN A QUALIFIED REHABILITATION FACILITY OR MULTI-SERVICE CENTER WHICH INCLUDES VOCATIONAL REHABILITATION SERVICES AS PART OF ITS PROGRAM.

Priority: Essential | Implementation Schedule: Short Term

This recommendation goes beyond the provisions of Title 15. It would mandate eligibility for traditional vocational rehabilitation services rather than include those so classified in a program specifically identified as a "poverty program".

Further, based on Task Group findings, it is found desirable to extend services in the current work adjustment and extended evaluation program to a period longer than six months. This is not sufficient time for those with Socio-Medical Handicaps to derive meaningful benefits.

S-M 7 ADEQUATE FINANCIAL SUPPORTS ARE NEEDED FOR THOSE ENTERING A VOCATIONAL REHABILITATION PROGRAM. SUPPLEMENTAL PAYMENTS TO SOCIO-MEDICALLY HANDICAPPED PERSONS SHOULD EQUAL NEW YORK STATE UNEMPLOYMENT INSURANCE BENEFITS, WITH AN ADDITIONAL WEEKLY AMOUNT OF $10 FOR EACH DEPENDENT TO A MAXIMUM OF $100.

Priority: Essential | Implementation Schedule: Short Term

Presently stipends are granted to DVR clients under certain circumstances, but the practice of granting such stipends varies considerably. Clients in a workshop placement are granted allowances of $25 weekly with $10 for each dependent, but not more than $65 weekly to any one individual.

These supplemental payments should be available to Socio-Medically Handicapped clients enrolled in a qualified rehabilitation facility meeting facility standards. Eligibility for such payments should be extended to those clients who are presumptively eligible for vocational rehabilitation services and for those accepted for service. Further, the amounts should be increased to equal New York State Unemployment Insurance levels with an added $10 weekly, and that such allowance be 100 percent reimbursable from federal funds. The Task Group has not been able to estimate the total costs of these changes, or of the number of persons with Socio-Medical Handicaps who may be eligible. The rehabilitation stipend would be the difference between other income, such as public assistance, public insurance payments, and private income received by the client and the maximum amounts herein proposed.

S-M 8 DEVELOPMENT OF REVISED INTAKE PROCEDURES IS REQUIRED TO ENABLE THE DIVISION OF VOCATIONAL REHABILITATION TO DETERMINE ELIGIBILITY MORE RAPIDLY. DEVELOPMENT OF REVISED ADMINISTRATIVE POLICY TO PERMIT ACCREDITED AGENCIES WITH CERTIFIED PERSONNEL TO FORMULATE REHABILITATION PLANS WITH CLIENTS IS NECESSARY.

Priority: Urgent Implementation Schedule: Interim

The time lapse from referral to acceptance for service by DVR is noted as excessive, and to those with Socio-Medical Handicaps it might tend to defeat intensive client preparation for services. Consistent and uninterrupted follow-through is required.

As a method of facilitating the referral procedure, accredited agencies employing certified personnel should be permitted to formulate rehabilitation plans with clients.

S-M 9 PROVISION SHOULD BE MADE TO PERMIT CERTIFIED PERSONNEL TO ESTABLISH PRESUMPTIVE ELIGIBILITY AND TO DEVELOP REHABILITATION PLANS WITH CLIENTS.

Priority: Urgent Implementation Schedule: Interim

Similarly, the state rehabilitation agencies should include in its revision of administrative procedures the concept of presumptive eligibility. Certified personnel should be permitted to establish presumptive eligibility and then permitted to develop rehabilitation plans with clients.

S-M 10 REHABILITATION FACILITIES SHOULD CONFORM TO MINIMUM STANDARDS GOVERNING FACILITY OPERATION AND INCLUDE PROGRAM CONTENT AS WELL AS PERSONNEL UTILIZATION. STANDARDS SHOULD ALLOW FOR THE EMPLOYMENT OF AIDE OR TECHNICIAN SPECIALISTS WITHIN A CAREER LADDER FRAMEWORK.

Priority: Urgent Implementation Schedule: Interim

Rehabilitation facilities providing services to the handicapped should be governed by uniform standards of operations. Discrepancies in service quality would be minimized. Such standards should include program content and prescribe the way personnel will be utilized. The team approach has been found particularly effective when aides who are able to reach out to the socially handicapped are employed. For this kind of specialist or technician a career ladder incentive system is vital.

S-M 11 ADVISORY GROUPS CONSISTING OF SERVICE CONSUMERS, SERVICE DELIVERERS AND COMMUNITY LEADERS SHOULD BE APPOINTED TO RELATE TO VARIOUS DVR OPERATIONAL LEVELS.

Priority: Urgent Implementation Schedule: Interim

An essential ingredient of a service continuum is that of social relevance. Not only must the administrative layer be responsive to community and group needs, so too must the professional echelon. Flexibility on the part of the practitioner in understanding client needs infers that client and professional learn from one another. Advisory groups would provide for such an exchange.

S-M 12 TO PROVIDE FOR PLANNING ON A CONTINUOUS BASIS, A PLANNING COUNCIL FOR EACH REGION IN NEW YORK STATE SHOULD BE ESTABLISHED. IT SHOULD BE COMPOSED, AS IS THIS REGIONAL ADVISORY COMMITTEE, OF A REPRESENTATIVE CROSS-SECTION OF THE COMMUNITY. A PROPERLY STAFFED SECRETARIAT WITH AN ADEQUATE BUDGET IS ESSENTIAL.

Priority: Urgent — Implementation Schedule: Interim

A planning council for each region appears to be justified, if only because of the nature of the relationship between the state and private agencies who are involved in the delivery of vocational rehabilitation services. With the need to develop administrative changes within the governmental and private agencies, such an interaction should facilitate coordination and integration of services.

S-M 13 TO IMPLEMENT OUTREACH AND CASEFINDING, AN EDUCATIONAL AND INFORMATIONAL CAMPAIGN DIRECTED TOWARD HEALTH PROFESSIONALS AND COMMUNITY BASED ORGANIZATIONS IS ESSENTIAL. IN-HOSPITAL OR AMBULATORY CARE CENTER, MEDICAL, NURSING, AND SOCIAL WORK STAFFS SHOULD BE TARGETS OF SUCH A PROGRAM SO THAT REFERRALS TO APPROPRIATE CENTERS CAN BE MADE.

Priority: Urgent — Implementation Schedule: Interim

An effective information and education program can aid in increasing the effectiveness of goal attainment - to reach those who need services and assure that needed programs are available. Specific groups to be reached are identified because they serve the Socio-Medically Handicapped also, and it is essential that they be informed of the value and importance of vocational rehabilitation.

ARTHRITIS

Incidence and Prevalence

Of an estimated 513,500 arthritic persons, approximately 105,000 require at least vocational rehabilitation screening. Such screening will reveal some who already are in work which is compatible with their disability, but the majority will be in need of individually planned vocational rehabilitation services.

It is estimated that approximately 9,000 new patients in New York City develop some form of rheumatic disease each year. Of these new patients, approximately 1,800 can be expected to become so disabled as to be limited in their ability to carry out their normal activities.

The Avnet data is helpful in that incidence of medical treatment for arthritis in Metropolitan New York City is at the rate of 30.3 per 1,000 persons. Applying this rate to the general population would result in an arthritic population of 333,000 persons.

Extent of DVR Services

It is estimated that perhaps 700 arthritic subjects were served by DVR during the period ending June 30, 1965. Of these, 211 arthritics were rehabilitated. Clearly, there is great discrepancy between this figure of 700 persons in all of New York State, and the estimated number of up to 105,000 adults with seriously disabling forms of arthritis in New York City who would benefit from vocational rehabilitation screening and services.

The Task Group notes that DVR has functioned cooperatively and well in the handling of patients with arthritis referred to it. The discrepancy appears to be due to a failure in casefinding and referral rather than to lack of cooperation or efficiency in DVR. On the other hand, additional staff would be of great help in eliminating the period of waiting which must now prevail, and obviously there will be need for a very much larger staff at DVR when casefinding and referral more nearly approach the number of patients who need these services.

Other Agencies Serving the Arthritic

The Task Group Report lists 33 voluntary family service and non-hospital agencies that offer services to arthritics as well as to others with different disabilities. These are general agencies, only one of which limits its services to the arthritic. Services range from social service, vocational counseling, patient information service, homemaker, transportation and other related services. Only eight of these agencies, five of them public, offer vocational counseling.

The Report further lists 76 hospitals or other medical facilities in New York City providing care for arthritic patients. Of these, 51 have an arthritis clinic and 12 have comprehensive arthritis programs, 11 of which are located in Manhattan. Vocational counseling is given in 12 of the 51 facilities.

The Task Group emphasizes that the listings are incomplete, and information as to hospitals which have comprehensive, organized programs for the diagnosis and management of patients with arthritis are particularly inadequate, and that the relatively few facilities offering such services should be looked on merely as examples of places where comprehensive programs exist.

A-1 THE STATE REHABILITATION AGENCY SHOULD SPONSOR AND SUPPORT THE ESTABLISHMENT OF A CLIENT (PATIENT) INFORMATION CENTER AND REFER THOSE WHO REQUIRE IT TO EVALUATION CENTERS. FOR PATIENTS WITH PHYSICIANS, THE REFERRAL IS TO BE DONE THROUGH THE PHYSICIAN.

Priority: Urgent Implementation Schedule: Long Range

The Arthritis Task Group gives highest priority to medical rehabilitation because the great majority of patients with arthritis require these measures before they can be candidates for vocational rehabilitation. It is emphasized that centers be provided to which patients can be referred for diagnostic study and formulation of comprehensive programs of management. An information center would make and coordinate such referrals with a minimum of waste of time and effort by patients and staff.

A-2 THE STATE REHABILITATION AGENCY, IN CONJUNCTION WITH APPROPRIATE HEALTH DEPARTMENTS, SHOULD DETERMINE THE AMOUNT AND DEGREE OF RESPONSIBILITY REQUIRED OF EACH FOR THE ESTABLISHMENT OF COMPREHENSIVE, ORGANIZED PROGRAMS THAT WILL ACCOMPLISH THE FOLLOWING:

a) Evaluation centers so staffed as to be able to give comprehensive evaluation and a detailed program of care - preferably so organized that they can serve private and insured, or indigent uninsured patients.

b) Out-patient facilities and services to which both private and insured and indigent uninsured patients can be referred for comprehensive ambulatory care. (These can be both private groups of physicians and institutions.)

c) General hospital beds staffed to provide comprehensive medical, psychiatric, orthopedic, social and psychological care to these same categories of patients with arthritis who require the facilities of a general hospital.

d) Intermediate care facilities able to provide constructive programs at low cost for patients who cannot receive optimal programs at home but do not require facilities of a general hospital.

e) In-patient facilities for patients requiring permanent care.

f) Home care services (See Recommendation A-20.)

g) Coordination of all the above to facilitate easy referral of patients back and forth depending on their needs.

h) Ideally some or all of these services should be provided within a single center on a fully coordinated basis.

i) Use of all the above for education of health related personnel.

Priority: Urgent Implementation Schedule: Long Range

Comprehensive programs require continuity of services, and obviously they require a broad range of service elements for which responsibility must be shared. To be effective, and to provide consistency, such a program as outlined above is considered minimal.

A-3 THE DIVISION OF VOCATIONAL REHABILITATION SHOULD CONDUCT A STUDY WITH APPROPRIATE STATE AGENCIES TO DETERMINE WHETHER PHYSICAL RESTORATION SERVICES COULD BE TRANSFERRED TO ANOTHER GOVERNMENTAL AGENCY OR TO MEDICAID.

Priority: Desirable Implementation Schedule: Short Term

At the present time DVR both arranges for and may pay for physical restoration services. There is some arrangement between the State Department of Health and the Division of Vocational Rehabilitation in that DVR is permitted to provide services to its own clients without requiring the State Health Department to do so. The Health Department is responsible for this service. What its role should be is worth exploring, particularly if funding possibilities can be developed.

A-4 THE NEW YORK CITY DEPARTMENT OF SOCIAL SERVICES, STATE EMPLOYMENT SERVICES AND DVR SHOULD STUDY THE BENEFITS ACCRUING FROM COMBINING THEIR TRAINING AND PLACEMENT ACTIVITIES.

Priority: Urgent Implementation Schedule: Short Term

There is a duplication of these programs offered by each agency. While program jurisdictions are separate, they really serve pretty much the same clientele. A possible benefit too, would be in a freer flow of staff between each of the agencies.

A-5 A STUDY SHOULD BE UNDERTAKEN AT THE DIRECTION OF THE GOVERNOR TO DETERMINE THE FEASIBILITY OF COMBINING A DEPARTMENT OF HEALTH AND MEDICAL REHABILITATION WHICH WOULD FUNCTION IN THOSE CONCERNED AREAS AND A DEPARTMENT OF VOCATIONAL EDUCATION AND PLACEMENT THAT HANDLED ALL JOB TRAINING AND PLACEMENT ACTIVITIES.

Priority: Urgent Implementation Schedule: Long Range

Such an agency structure would have the advantages of economy in the use of money, material resources, manpower, and consistency of policy, and the power to implement change and growth.

A-6 DVR, ORGANIZED MEDICAL SOCIETIES, REHABILITATION AGENCIES, OR REHABILITATION-RELATED ORGANIZATIONS SHOULD JOINTLY SPONSOR LEGISLATION REQUIRING THAT ALL BUILDINGS ELIMINATE ARCHITECTURAL BARRIERS.

Priority: Urgent Implementation Schedule: Interim

Architectural barriers present formidable problems to the handicapped person. New York City does not have a formal policy in this matter. The rehabilitation community should press for passage of legislation so that buildings and other facilities used by the public will be so constructed as to make them usable by seriously handicapped persons.

A-7 APPROPRIATE LEGISLATION SHOULD BE SPONSORED BY THE REHABILITATION COMMUNITY AND RELATED HEALTH SERVICE PRACTITIONERS THAT WOULD PROVIDE EXTENSION OF INSURANCE COVERAGE TO ENSURE THAT ALL PEOPLE CAN OBTAIN MEDICAL AND REHABILITATION SERVICES, WHICH CAN BE SO COSTLY IN THE CASE OF CHRONIC DISEASES LIKE ARTHRITIS.

Priority: Essential Implementation Schedule: Long Range

For the chronically handicapped person, medical costs are prohibitive. When rehabilitation services are required they are also expensive, and consideration should be given to the funding possibilities inherent in insurance coverage for these services, thus relieving government agencies of some of the tax cost in the provision of such services.

Administrative Policy

A-8 DVR SHOULD CREATE AND DEVELOP A SPECTRUM OF EMPLOYMENT OPPORTUNITIES FOR THE HANDICAPPED ARTHRITIC PATIENT VARYING FROM THE TOTALLY PROTECTED, NON-COMPETITIVE PERMANENT SHELTERED WORKSHOP WHICH INDUSTRY SHOULD BE ENCOURAGED TO DEVELOP WITHIN THEIR OWN PLANTS, TO COMPETITIVE EMPLOYMENT.

Priority: Essential Implementation Schedule: Short Term

A larger number of placements for the arthritic client is needed in order to accommodate a greater number of persons. A variety of different types of placements are needed to match functional capacities of clients. In doing so, industry should be involved on a larger scale and inducements offered in order to encourage industrial involvement in training and employing the handicapped. (See Recommendation A-10.)

A-9 SPECIFIC PROGRAMS SHOULD BE DEVELOPED BY DVR AND REHABILITATION FACILITIES GEARED TO SERVE CLIENTS WITH ALL TYPES OF BACKGROUNDS AND CAPACITIES AND NOT MERELY THOSE CAPABLE OF LIGHT FACTORY WORK.

Priority: Urgent Implementation Schedule: Interim

Skill upgrading is a responsibility of all rehabilitation facilities. The handicapped often need help in raising the level of their academic education prior to vocational training. Serving the disadvantaged and patients with different backgrounds will require new approaches and changes in program content. A study should be undertaken to determine how this can be accomplished.

A-10 DVR AND THE REHABILITATION COMMUNITY SHOULD SPONSOR THE ENACTMENT OF LEGISLATION REQUIRING THE EMPLOYMENT OF THE HANDICAPPED WITH, IF NECESSARY, TAX OR OTHER FINANCIAL INCENTIVES TO INDUSTRY. (See Recommendation A-8.)

Priority: Urgent Implementation Schedule: Interim

Such legislation would stimulate and create more placements of the handicapped in competitive employment.

A-11 DVR SHOULD UNDERTAKE A REVIEW OF ITS PERSONNEL PROGRAM, GIVING ATTENTION TO THE FOLLOWING RECOMMENDATIONS, AND TAKE APPROPRIATE ACTION TO ADOPT POLICY, OFFER LEGISLATION, OR PROVIDE FUNDS FOR:

a) Development of recruitment programs to encourage grammar school, high school and college students to become interested in careers in the health professions

b) Establishment of more high school, college and graduate courses leading to certificates and diplomas in the health fields

c) To encourage the above, financial aid programs of all kinds such as scholarships, fellowships, traineeships, scholar incentive awards, teaching and construction grants to institutions

d) Reappraisal of professional educational requirements with the purpose of shortening the period required for the various professional degrees - medical and paramedical

e) Greater effort at recruitment and training of personnel of less than collegiate grade in the paramedical fields to help meet the shortages in the fully qualified personnel

f) Recognition of supervised experience, on-the-job training, and ability to meet graded work performance criteria in entry into and advancement in the health, education, and welfare fields

g) Removal of professional licensing barriers and other restrictions to enable trained paramedical personnel from other states and countries to take positions in New York

h) Inclusion of at least brief periods of experience in the hospital in the training of health related personnel

i) Programs for the training of physicians and other health personnel in the special features involved in the comprehensive care of arthritic patients

j) Provision of salaries adequate to attract and hold able people in the health professions. This means salaries substantially higher than those current

k) Recognition that continued growth and proficiency of professional personnel requires attendance at professional meetings and advanced study and research, and provision of administrative and financial arrangements to encourage these activities.

Priority: Urgent Implementation Schedule: Short Term

Each item above relates to the concern with manpower. Manpower needs are great if the serious bottleneck of insufficient personnel in the health related fields is to be overcome.

Inter-Agency Relations

A-12 DVR SHOULD ESTABLISH STANDARDS FOR ALL VOCATIONAL TRAINING FACILITIES OR PROGRAMS AUTHORIZED TO RECEIVE FEES THROUGH DVR.

Priority: Urgent Implementation Schedule: Interim

Setting standards would assure high quality care and service programs for those working with the handicapped. Because of the financial incentives, rehabilitation agencies would be encouraged to upgrade their programs and offer a wider range of services. In addition, some consideration can be given to better coordination of services and easier referral methods.

A-13 DVR SHOULD UNDERTAKE A STUDY THAT WOULD DETERMINE THE NEED FOR ADDITIONAL REHABILITATION FACILITIES IN EACH OF NEW YORK CITY'S COUNTIES, AND DETERMINE WHETHER THERE IS A NEED FOR SPECIALIZED FACILITIES FOR THE ARTHRITIC AND HOW MANY ARTHRITICS COULD BE SERVED IN FACILITIES FOR PATIENTS WITH ANY CHRONICALLY DISABLING DISEASE.

Priority: Urgent Implementation Schedule: Interim

It is possible that more arthritics could be served in the community if there were more facilities to accommodate them. It is preferable to involve the arthritic in a generalized agency, but it is unknown how many more patients could be served and what the agencies' capacities might be. A study would reveal this.

A-14 DVR SHOULD ACCEPT THE PRINCIPLE THAT VENDORS OF SERVICE ARE ENTITLED TO FULL AND PROMPT REIMBURSEMENT FOR THEIR SERVICES AND SHOULD TAKE STEPS TO IMPLEMENT THIS PRINCIPLE.

Priority: Urgent Implementation Schedule: Interim

Some facilities from whom DVR purschases service have had to wait too long before receiving payment. This has placed an undue hardship on them and it should be alleviated.

A-15 DVR, IN THE PLANNING AND ADMINISTERING OF REHABILITATION SERVICES, SHOULD CREATE A CONSULTANCY GROUP CONSISTING OF LAWYERS, ARCHITECTS, ENGINEERS AND MANAGEMENT CONSULTANTS.

Priority: Urgent Implementation Schedule: Interim

Planning and administration often requires the professional insights of qualified people who can often make significant contributions to agency operations.

A-16 DVR, IN UNDERTAKING ONGOING PLANNING FOR VOCATIONAL REHABILITATION SERVICES, SHOULD PROVIDE FOR A FORMAL COMMUNICATIONS STRUCTURE WITH ITS PROFESSIONAL STAFF AS WELL AS THE REHABILITATION COMMUNITY.

Priority: Urgent Implementation Schedule: Interim

In the establishment of an ongoing mechanism, a communications and an information exchange system is needed; every professional person should be reached and informed about planning goals and problems. Much depends on the way plans are developed, presented and implemented. Real communication and shared planning can lead to new attitudes and work patterns.

Programs

A-17 **DVR SHOULD SUBMIT LEGISLATION OR ADOPT POLICY, WHICHEVER IS APPROPRIATE, TO PROVIDE RECREATIONAL SERVICES FOR THE ARTHRITIC.**

Priority: Urgent — Implementation Schedule: Long Range

Recommendations 17, 18 and 19 broaden the services which should be made available on a more consistent basis. The need for recreational programs as part of comprehensive services is apparent. It is not now provided on a systematic programmed basis; rather individual facilities offer recreation, when they can afford it, as program supplements. It should be regularized.

A-18 **DVR SHOULD SUBMIT LEGISLATION OR ADOPT POLICY, WHICHEVER IS APPROPRIATE, TO EXPAND HOMEBOUND SERVICES TO THE ARTHRITIC WHICH WOULD INCLUDE VOLUNTEER PARTICIPATION IN SUCH PROGRAMS.**

Priority: Urgent — Implementation Schedule: Long Range

Services to the homebound presently are provided on a limited scale, and few voluntary agencies do so. Many more people could benefit from expanded services in this area. To stimulate such a service, it may be necessary to enact specific legislation to permit volunteers to render some of these services and to provide them with insurance and related protection. (See Recommendation A-20.)

A-19 **DVR SHOULD SUBMIT LEGISLATION OR ADOPT POLICY, WHICHEVER IS APPROPRIATE, TO PROVIDE TRANSPORTATION SERVICES TO MAKE ALL OTHER SERVICES READILY AVAILABLE. THIS SHOULD INCLUDE:**

a) Public transportation adapted to disabled people

b) Special transportation of patients to various facilities and services, and to jobs

c) Transportation of health-service personnel to the patient when a necessary part of the work requires it

d) Legislation to make tax deductible the extra personal cost to crippled people of transportation to enable them to get to work

Priority: Urgent — Implementation Schedule: Interim

Transportation needs for the handicapped are seriously neglected. Providing some relief for this problem gives acceptance to the principle that it is much better for the handicapped person to be employed outside the home rather than in it, even if it requires special transportation.

A-20 **DVR SHOULD ADOPT POLICY OR INITIATE LEGISLATION COMPATIBLE WITH THE PROVISION OF COMPREHENSIVE SERVICES (See Recommendation A-2) TO THE HANDICAPPED THAT WOULD ENABLE THE REHABILITATION AGENCY TO:**

a) Provide social work, homemaker and related services

b) Provide special housing to enable patients, whenever possible, to be cared for in their own homes instead of entering chronic care institutions

Priority: Desirable — Implementation Schedule: Long Range

It is recognized that homemaker and housing needs are the responsibility of the Department of Social Services, and homemaker services, at least, are offered by some private voluntary agencies. However, it is felt that the rehabilitation agency and the voluntary facilities who choose to develop programs for the homebound that include homemaker service should share in this responsibility. Similarly, special housing needs of clients eligible for rehabilitation services ought to be met in part by the agency, although DVR can under present policy pay for certain interior alterations to facilitate use of household amenities by the handicapped person.

But more essential is special housing for chronically ill persons as an alternative to chronic care institutions. Here the obligation of the public health and welfare agencies is the dominant one, but where it is agreed that an institutionalized person could be accepted by DVR for service, then some sharing of cost in the operation and maintenance of special housing would be expected. (See Recommendation A-18.)

RESPIRATORY HANDICAPS

Incidence and Prevalence

Most of the statistical data contained in the report is for tuberculosis, and here the figures are most reliable since they are obtained from Health Department records. Not only is there a Tuberculosis Register, but as a reportable disease accurate information is obtained on new cases of tuberculosis reported annually.

In 1966, the Tuberculosis Register listed 5,028 persons. For the same year, 11,651 persons received chemotherapy for tuberculosis in the New York City Department of Health Clinics. In New York City there were 3,663 new cases of tuberculosis reported during 1966. No projections were made for 1970 or 1975.

The Task Group noted the increase in epidemiologic trends in emphysema and chronic bronchitis, two crippling and often fatal conditions. Based on observations as reported in the literature, the prevalence of chronic obstructive respiratory disease is judged to be widespread in the New York City area. Mortality trends indicate that the problem is one of increasing magnitude. Other pulmonary handicaps such as asthma, bronchiectasis and pulmonary fungal infections, to name a few, occur with sufficient frequency to provide a high service priority for persons with non-tuberculous pulmonary handicaps.

Chronic bronchitis and emphysema (constituting an entity referred to as Chronic Obstructive Pulmonary Disease) rank second to heart (and circulatory) ailments as a basis for Social Security Disability payments.

The Avnet Study lists the following incidence data for 1964 in Metropolitan New York City, with rates based per 1,000 persons (exposure years) attended by a physician. It should be noted, however, that the conditions reported are undifferentiated and do not reflect which cases are acute or chronic or result in marked limitation of functional capacity.

Condition	Rate per 1000 Persons
Bronchitis	87.7
Asthma	14.1
Other Diseases of Respiratory Tract	178.9

Extent of Services

The number and types of persons with pulmonary handicaps, and those among them who have been rehabilitated, reveal a very wide disparity between the patient population and those who now receive DVR services.

A total of 3,663 new active cases of tuberculosis was reported in New York City in 1966. The gross number of new patients who could have been screened for service in 1966 was 2,846 excluding those under 14 and over 65.

In the last year for which data are available (1965), it is estimated that 235 tuberculosis patients were rehabilitated in New York City. There is an excess service gap from a potential service load of 2,846 to actual rehabilitation of 235 in roughly comparable time periods.

The volume of persons with non-tuberculosis pulmonary handicaps is also judged to be far in excess of the number to whom rehabilitation services are currently provided.

There is a pronounced lack of continuity in planning and service for rehabilitation among all patients with pulmonary handicaps, particularly for those whose treatment is initiated in hospitals and continued in clinics. Services for those patients should be planned by qualified in-hospital teams with continuity provided by clinic, public health, DVR, or other community agency personnel following hospital discharge.

Client Characteristics

For comparative purposes the following statewide data is offered as reported in Facts in Brief for 1965.

Age: The median age of the 352 tuberculosis persons who were rehabilitated in 1965 was 32. The median age of all persons in New York City reported to have been diagnosed with tuberculosis in the same year was 41 according to the New York City Tuberculosis Register maintained by the New York City Department of Health.

Sex: Nearly half (46%) of the 352 tuberculosis persons who were rehabilitated in 1965 were females. However, in New York City two-thirds (65%) of all newly reported cases were males.

Dependency: Less than half of the 352 tuberculosis persons rehabilitated in 1965 were welfare recipients before rehabilitation. It is estimated that 65% to 75% of all patients receiving clinic care for tuberculosis in New York City are welfare recipients.

Thus, it is observed that tuberculosis patients in New York City as a group are older, more frequently males, and more often welfare recipients than are those tuberculosis patients who were rehabilitated by DVR. While the number of persons with non-tuberculosis pulmonary handicaps who are given DVR services are not available, it is presumed to be a very small proportion of the potential caseload.

Eight municipal hospitals operate chest services which treat patients with all types of pulmonary handicaps; Tuberculosis patients constitute a large majority, but patients with a variety of other lung conditions are also treated in these institutions and their out-patient departments. In addition, the Department of Health operates 23 Tuberculosis clinics and provides staff and other support to chest clinics operated in the municipal hospitals. Many of the large voluntary hospitals in New York City operate chest clinics as out-patient services.

Eleven voluntary agencies provide either workshop facilities or counseling or referral services. No information is available on the number of clients served.

R-1 A STUDY SHOULD BE UNDERTAKEN TO CONSIDER THE ESTABLISHMENT OF A CENTRALIZED REHABILITATION AGENCY WITH ADEQUATE FINANCIAL AND STAFF SUPPORTS.

Priority: Urgent Implementation Schedule: Long Range

In recognizing the need for coordinated and integrated client services, the obvious discrepancy between those obtaining services and those who need them, larger numbers of people can and must be brought into a rehabilitation focus. Continuity of services beyond hospital discharge is desirable. A stronger centralized agency should be able to meet this need. However, mere introduction of another administrative level in the system should be avoided. This type of planning might be explored with persons specialized in working with the centralization-decentralization and generalization-specialization dilemmas in administration.

R-2 AN ORDERLY, COMPREHENSIVE REFERRAL SYSTEM SHOULD BE ESTABLISHED, BOTH WITHIN HOSPITALS AND IN THE COMMUNITY BY DVR AND OTHER AGENCIES PROVIDING SERVICES TO THE DISABLED.

Priority: Urgent Implementation Schedule: Short Term

Ideally, fully staffed Departments of Physical Medicine and Rehabilitation would screen all patients admitted to their respective hospitals. For those with chronic respiratory handicaps, team planning which considers clinical, social, economic and vocational needs should be conducted within the hospital. Upon discharge of the patient, the plan should be activated in the community without interruption or delay.

Administrative Policy

R-3 DVR SHOULD ESTABLISH A UNIFORM INTAKE SERVICE IN ALL HOSPITALS AND CLINICS.

Priority: Urgent Implementation Schedule: Interim

This should be carried out in close association with appropriate institutional officials, such as the staff of Departments of Physical Medicine and Rehabilitation, where such exist and function with respiratory disease patients.

R-4 DVR SHOULD IMPROVE INTAKE AND SERVICE PROCEDURES TO ELIMINATE LONG DELAYS IN PROVIDING SERVICE.

Priority: Urgent Implementation Schedule: Interim

Many tuberculosis patients become discouraged with delays and do not follow the process through to completion for this reason.

R-5 DVR SHOULD ADD TO ITS COUNSELOR STAFF AND ASSIGN A CERTAIN NUMBER OF THEM TO A "FIELD STAFF".

Priority: Urgent Implementation Schedule: Interim

Added staff is needed to speed up and improve service as well as make it available to more clients. A "field staff" (out-stationed personnel) would bring service to patients who are in hospitals, at home, or otherwise not likely to become clients at the DVR office.

R-6 DVR BUDGET SUPPORT SHOULD BE PROVIDED TO PERMIT EXPANDED CENTRAL SERVICES.

Priority: Urgent Implementation Schedule: Interim

Financial increases will be necessary to support a much enlarged counselor staff and expanded direct services.

R-7 DVR SHOULD TAKE APPROPRIATE STEPS TO DEVELOP A POLICY WHICH WOULD ALLOW UTILIZATION BY DVR OF QUALIFIED PROFESSIONAL WORKERS EMPLOYED BY COOPERATING AGENCIES TO DEVELOP REHABILITATION PLANS WITH AGENCY CLIENTS.

Priority: Urgent Implementation Schedule: Interim

This would help in solving the manpower shortage in DVR and would eliminate delays in DVR intake. Further study of how to better utilize available personnel and how to establish standards of qualifications are needed.

R-8 DVR SHOULD ESTABLISH A PUBLIC INFORMATION PROGRAM.

Priority: Urgent Implementation Schedule: Interim

The agency responsible for providing rehabilitation services should develop a public information program designed to inform practitioners and public alike of the range of services which are available.

R-9 LEGISLATION SHOULD BE PREPARED BY DVR WHICH WOULD MODIFY ELIGIBILITY REQUIREMENTS IN ORDER TO PROVIDE SERVICE FOR MANY WHO NEED SOCIAL REHABILITATION AS WELL AS VOCATIONAL REHABILITATION.

Priority: Essential Implementation Schedule: Long Range

Those whose vocational future is limited by social obstacles are presently not provided service by DVR to any great extent. They are a large group whose dependency will be permanent unless appropriate services are provided.

R-10 ADDITIONAL LEGISLATION OR INCLUSION IN THE STATE PLAN IS REQUIRED FOR PROVISION OF VOCATIONAL REHABILITATION SERVICES TO PERSONS HANDICAPPED BY COMPLEX PERSONAL AND FAMILY PROBLEMS.

Priority: Essential Implementation Schedule: Long Range

Inter-Agency Relations

R-11 CONTINUATION OF PLANNING FOR REHABILITATION SERVICES WITH COMMUNITY PARTICIPATION SHOULD BE THE RESPONSIBILITY OF DVR.

Priority: Urgent — Implementation Schedule: Interim

This is indicated in order to provide for flexible and responsive programming.

R-12 DVR AND THE FEDERAL VOCATIONAL SERVICES ADMINISTRATION SHOULD ADOPT A POLICY AND PROVIDE FUNDING FOR STAFFING GRANTS WITHIN HOSPITALS AND CLINICS PROVIDING REHABILITATION MEDICINE SERVICES.

Priority: Desirable — Implementation Schedule: Short Term

Supplementation of Physical Medicine and Rehabilitation Departments is necessary in order to screen patients and develop plans appropriate for individual patients with respiratory handicaps.

TRAUMA AND ORTHOPEDIC HANDICAPS

Incidence and Prevalence

The Task Group Report does not contain any data which estimates those who would require vocational rehabilitation services. Nor has there been delineation of specific disabilities which would be included within its area of study. In order to make some projections, the following chronic conditions are included, for which some data is available:

Paralysis, complete or partial
Impairment of back or spine
Impairment of upper extremities and shoulders
Impairment of lower extremities and hips

It is to be noted that the specific diagnostic categories are not given, and for this reason there may be duplication in the estimates, or for that matter, gross omissions. Because of the lack in uniformity of reporting, no really reliable data is available.

TABLE I

Estimated Number of Selected Chronic Conditions Among Persons
Unable to Carry on Major Activity for 1965, 1970, 1975 - New York City*

Condition	1965	1970	1975
Paralysis	23,927	25,692	27,353
Impairment of Back or Spine	8,818	9,469	10,081
Impairment of Upper Extremities	2,751	2,954	3,144
Impairment of Lower Extremities	14,186	15,233	16,217
TOTALS	49,680	53,348	56,795

*Adapted from General Handbook for Comprehensive Statewide Planning for Vocational Rehabilitation Services, New York State Education Department, Office of Statewide Planning for Vocational Rehabilitation Services, Albany, New York, June 1967

Extent of Services

The Task Group indicated that criticism of DVR service lies not so much with the extent of service as with the quality of individual service including the counselor's attitude toward clients and other agencies.

Factors influencing service quality were defined:

- content of counselor's education courses
- size of caseload affecting negatively the time for alternative solutions and for follow-up
- method of recruitment of counselors
- the organizational system that gives great power to counselor's decisions
- lack of routine "court of appeal" within the DVR organization for those clients and agencies in disagreement with counselor's decisions

The extent of services offered by voluntary agencies also suffers from certain limitations. The level of existing physical medicine, orthopedic, neurological and amputee clinics in various neighborhoods should be upgraded. This is especially true in Queens and Richmond. More comprehensive approaches are needed that include social workers for family and community problems, occupational therapists, psychologists and rehabilitation counselors to develop a team of specialists able to undertake an extensive work-up and make expeditious referrals to appropriate agencies for vocational rehabilitation, or whatever other service might be indicated.

Program gaps which have been identified as existing in the following areas:

a) terminal sheltered workshop facilities

b) avocational programs for those even below sheltered workshop functioning

c) recreational programs in the evenings and on weekends for working patients, or for those in sheltered workshop placement

d) for the adolescent with trauma, there is a need for more extensive guidance - within the regular school program, business, trade and vocational classes for the handicapped should be provided

e) placement offices should be established in hospitals to assist trauma patients who are ready for employment, and these offices should develop links with local stores, hospitals, and factories which promote the hiring of the handicapped

f) there is dire need to educate the public about the positive work skills of the handicapped

g) colleges, universities and high schools should be involved in a consistent way that will make them aware of many future opportunities for employment in the health fields

h) a practical transportation system for the non-ambulatory or semi-ambulatory person that would operate not only during the rehabilitation process, but during the employment years, and for recreation and other social rehabilitation purposes

i) a clear nomenclature of disabling conditions that would allow for better interpretation of laws, more effective record keeping, uniformity in reporting, and an improved basis for program planning.

T-1 A CLEAR NOMENCLATURE OF DISABLING CONDITIONS SHOULD BE DEVELOPED. DVR SHOULD, EITHER FROM ITS OWN FUNDS OR BY APPLICATION TO AN APPROPRIATE FEDERAL AGENCY FOR FUNDS, DEVELOP A METHODOLOGY THAT LEADS TO FRAMING OF A NOMENCLATURE OF DISABLING CONDITIONS.

Priority: Essential Implementation Schedule: Interim

Uniformity of nomenclature is most desirable in the administration of rehabilitation programs and invaluable in the preparation of referral material. Other benefits and applications are noted in (i) above.

T-2 A SEQUENTIAL REHABILITATION PROCESS (SERVICE CONTINUUM) SHOULD BE DEVELOPED AND A STUDY UNDERTAKEN BY HEALTH, HOSPITAL, WELFARE AND VOCATIONAL REHABILITATION DEPARTMENTS ON STATE AND CITY LEVELS TO DETERMINE HOW IT SHALL BE IMPLEMENTED.

Priority: Urgent Implementation Schedule: Interim

A rehabilitation process should ideally show the various stages that a patient might pass through from time of medical diagnosis to recovery at his optimum level of performance. It would provide for early entry into vocational planning with joint participation of various disciplines in the planning so that a patient is not officially "handed over" from one department to another without group understanding and decision. Such a study would show how the various service deliverers would cooperate in developing an effective rehabilitation process.

Administrative Policy

T-3 DVR SHOULD UNDERTAKE AN EXTENSIVE STUDY FOR THE IMPROVEMENT OF ITS ADMINISTRATIVE AND OPERATIONAL PROCEDURES.

Priority: Urgent Implementation Schedule: Interim

The goals of such a study would be to determine an adequate caseload size, to stimulate and influence the content of vocational rehabilitation counseling courses, counselor recruitment, developing more objective criteria for counselor's decisions to accept or reject clients, and a routine "court of appeals" or other appellate process that is meaningful with encouragement for its utilization. In addition, in-service training for all supervisory and counselor personnel should be held at stated intervals with attention paid to counselor attitudes toward clients and other service agencies.

T-4 AS A MATTER OF POLICY, DVR SHOULD GIVE PRIORITY TO DISABLED ADOLESCENTS AND UNDERTAKE THE ESTABLISHMENT OF JOINT PROGRAMS WITH THE NEW YORK CITY BOARD OF EDUCATION, SUCH AS MORE EXTENSIVE GUIDANCE AND PROVISION OF BUSINESS, TRADE AND VOCATIONAL CLASSES WITHIN THE REGULAR SCHOOL SYSTEM.

Priority: Urgent Implementation Schedule: Short Term

It is possible to avoid repetition of many problems in later life if priority were given to the teenager, whose need for intensified service is apparent. In implementing this recommendation, agreements between participating agencies should include professional assignments, course content and allocation of costs.

T-5 DVR SHOULD ESTABLISH A PUBLIC INFORMATION AND EDUCATION SERVICE.

Priority: Urgent Implementation Schedule: Interim

There is a dire need to educate the public about the positive work skills of the handicapped. Similarly, there is a need to stimulate recruitment to the counseling profession and to promote wider acceptance of the concepts of rehabilitation among professional groups as well as the public at large.

Inter-Agency Relations

T-6 DVR SHOULD STIMULATE AND GIVE FINANCIAL SUPPORTS TO THE UPGRADING OF PHYSICAL MEDICINE, ORTHOPEDIC, NEUROLOGICAL AND AMPUTEE SERVICES WHICH RELATE DIRECTLY TO THE VOCATIONAL REHABILITATION SYSTEM.

Priority: Essential Implementation Schedule: Short Term

While it is recognized that the provision of health care in clinical settings is the responsibility of hospitals and their regulating agencies, DVR should nevertheless stimulate more effective rehabilitation-related services by offering financial incentives on a matching basis. In so doing, guidelines are needed to provide for such techniques as specialist teams whose focus would be extensive work-up leading to needed referral to appropriate community agencies.

T-7 DVR SHOULD PLAN FOR THE DEVELOPMENT OF TERMINAL SHELTERED WORKSHOPS FOR THE SEVERELY DISABLED BY SPONSORING NEEDED LEGISLATION OR TAKE APPROPRIATE MEASURES TO ENCOURAGE AND ESTABLISH SUCH FACILITIES. CONSIDERATION SHOULD BE GIVEN TO A POLICY OF MAKING TERMINAL SHELTERED WORKSHOPS A PART OF LARGER WORKSHOP FACILITIES, BUT NOT AUTONOMOUS, AND FURTHER, CONSIDERATION SHOULD BE GIVEN TO ESTABLISHING A CENTRAL AGENCY TO ADMINISTER SUCH FACILITIES.

Priority: Essential Implementation Schedule: Long Range

In recognition of the need to give services of an ongoing and continuous nature to severely disabled persons who can rarely fit into a structured and competitive labor market, a more extended care facility is necessary. This kind of workshop should be closely related to established rehabilitation facilities, and thus to benefit from the experience and economies accruing to accommodating long-term workshop placements in an established agency.

T-8 LEGISLATION IS NECESSARY TO ENABLE DVR TO INCLUDE SERVICES TO THE HANDICAPPED WHICH ARE AVOCATIONAL, RECREATIONAL, OR SOCIAL IN NATURE.

Priority: Desirable Implementation Schedule: Long Range

Avocational programs for patients who are below sheltered workshop functioning are necessary. The need for recreational, social and educational programs during the day is tremendous, and largely overlooked. There are many trauma patients who are homebound or whose disabilities prevent them from working or participating in group experiences. By providing such programs, the handicapped person would be getting a truly comprehensive range of services. This would apply, too, to needed recreation programs for the handicapped during evenings and weekends. By authorizing services of this kind, voluntary agencies would be encouraged to provide them as part of a comprehensive rehabilitation facility.

T-9 IN BROADENING THE SCOPE OF SERVICES TO BE PROVIDED BY VOCATIONAL REHABILITATION LEGISLATION, PROVISION SHOULD BE MADE TO ESTABLISH PROGRAMS WITH VOLUNTARY AGENCIES THAT WOULD PROVIDE FOR FINANCIAL SUPPORT FOR SERVICES THAT FOSTER INDEPENDENT LIVING SUPPORTS FOR PERSONS BETWEEN 16 AND 20 YEARS OF AGE WHO DO NOT MEET DVR ELIGIBILITY REQUIREMENTS.

Priority: Desirable Implementation Schedule: Long Range

For those who do not meet DVR acceptance standards or who may have failed in the vocational rehabilitation process, some organized program is justified to encourage the handicapped person to participate in non-vocational pursuits, but calculated to make him function more independently in daily activities. Such services could be programmed to reintroduce the client to the full range of DVR services.

T-10 PLACEMENT OFFICES, WITH APPROPRIATE PERSONNEL, SHOULD BE ESTABLISHED IN HOSPITALS TO ASSIST TRAUMA PATIENTS WHO ARE READY FOR EMPLOYMENT AFTER MEDICAL TREATMENT. OPERATION OF SUCH AN OFFICE SHOULD BE DELEGATED TO EITHER THE STATE EMPLOYMENT SERVICE OR DVR OR JOINTLY.

Priority: Desirable Implementation Schedule: Long Range

By including a placement service in a hospital, the patient is exposed to a positive goal expectation rather early in the course of his medical rehabilitation. A placement office would, of course, operate under a rehabilitation team which would decide whether or not such a referral for employment should take place after hospitalization or after a period of convalescence.

PART III

PLANNING OPERATIONS
# of the
REGIONAL ADVISORY COMMITTEE

PLANNING OPERATIONS OF THE REGIONAL ADVISORY COMMITTEE

Introduction

In little more than one year, the more than 150 New Yorkers who accepted the challenging invitation to participate in planning for improved vocational rehabilitation services have produced a substantive and important product. From the convening of the first meeting of the Regional Advisory Committee on December 8, 1967 until the submission of the Task Group Reports in September 1968, the involvement was intensive and dynamic. Despite the inevitable frustrations and the inability to complete each aspect of the planning design, the data presented in the New York City Regional Report is a tribute to those who worked so diligently in discharge of their responsibilities.

From the tenor of the discussions surrounding the content of this report and its implications, there is reason to believe that the result of this effort is only the first step toward significant change in the delivery of vocational rehabilitation services. Concern for implementation of recommendations in the immediate future will assure not only continued community participation and interest, but that active concern for regional needs as they have been identified here will keep alive the need for change. With the submission of the Regional Report, substantive planning will have just begun.

What follows here are highlights of the planning operations of the New York City Regional Advisory Committee. Included will be the structure, function, and procedures adopted together with the results of committee interaction and relationships established between the regional planning office and other community organizations.

Initial Organization

With the appointment of the New York City Regional Planning Director in February 1967, the organization of Region I began. The first few months were spent in concurrent efforts to recruit members for the Regional Advisory Committee and in the development of both statewide and regional planning guidelines.

In June 1967, the Office of Statewide Planning for Vocational Rehabilitation Services (headquarters in Albany) published a General Handbook for Advisory Committee Members. And, during the succeeding months, a series of issue papers was prepared to supplement the Handbook. All materials were designed to orient committee members who were newcomers to the field of rehabilitation and also to give a framework for the conduct of the planning process. The desire was to obtain uniformity of operation and coverage throughout the state.

With the designation of the first members of the Executive Committee in the fall of 1967, the first glimmering of what was to prove an independent minded committee began to show. The somewhat prosaic and structured guidelines presented by the Statewide Planning staff (including the New York City Regional Planning Director) underwent steady and consistent change.

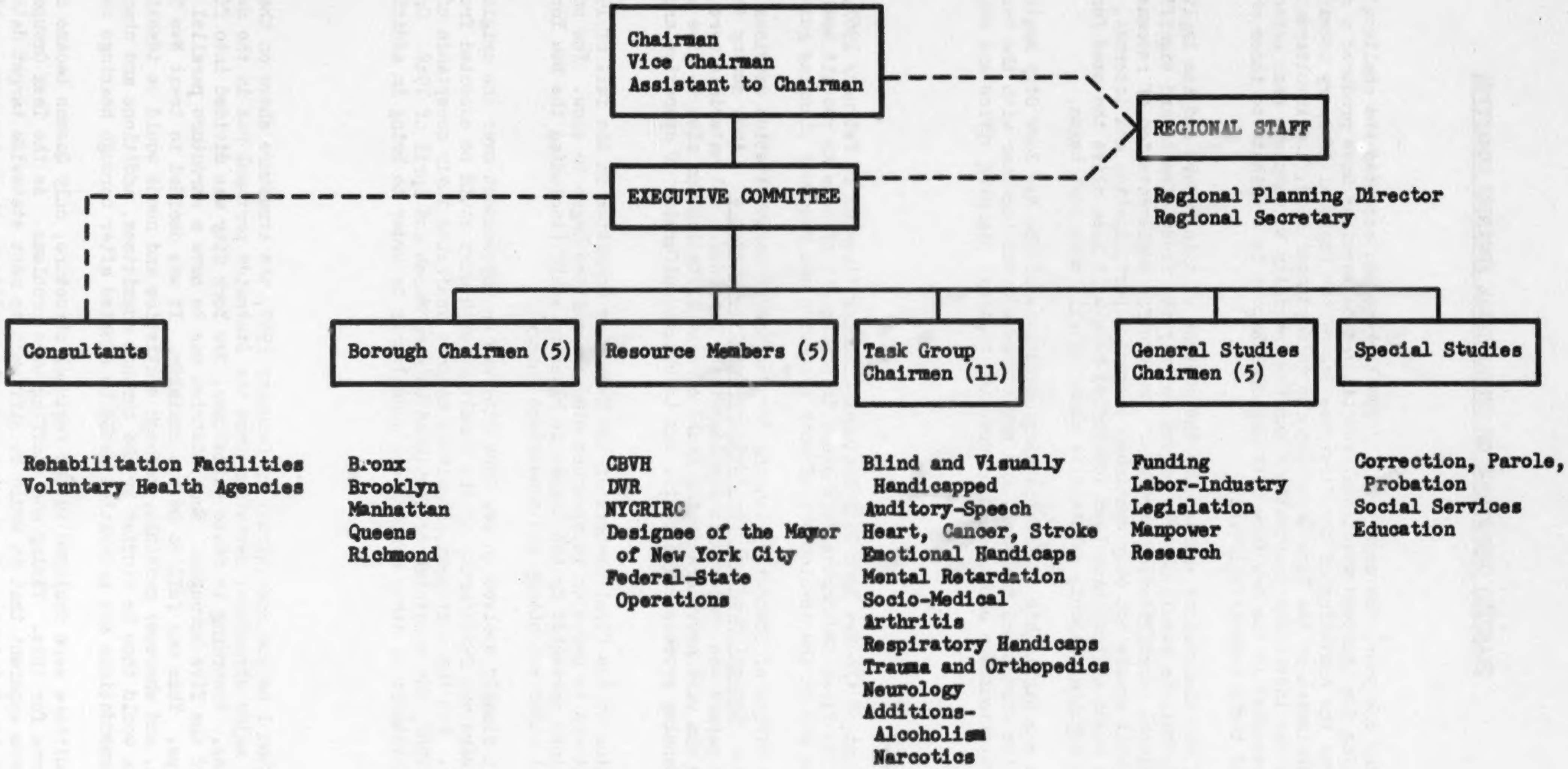
The structure that finally evolved in New York City was an improvement over the original design and reflected the knowledge and familiarity of the committee with what could be expected from such a diverse group of planners. For the most part, committee members indicated their acceptance of membership between June and October 1967, but appointments continued between March and April of 1968. Committee members recommended the appointment of other members and consultants in order to bring in additional professional and technical skills.

Structure

Shortly after Region I became operational in December 1967, the structure shown on the Chart (page 108) was adopted. The major structural deviation from the Statewide protocol was in the decision to abandon district committees. According to State guidelines, New York City was divided into five districts corresponding to each of the five boroughs. Each district was to have a structure parallel to the Region, including Task Groups. This was felt to be too unwieldy. It was decided to treat New York City as a whole in obtaining data, and wherever possible, borough statistics and needs would be identified by the Task Groups. This data would then be studied by the borough committees, additions and changes would be made, and a set of recommendations and priorities would be adopted after borough hearings were held.

While borough committees were included in the regional structure, only Queens became operational. There were several reasons for this. Timing and staffing were problems. As the Task Groups continued with their work, it soon became apparent that it would be difficult to meet statewide target dates. Because there was insufficient staff to administer and organize borough committees, they were never activated.

STRUCTURE OF REGIONAL ADVISORY COMMITTEE


Chairman
Vice Chairman
Assistant to Chairman
REGIONAL STAFF
Regional Planning Director
Regional Secretary
EXECUTIVE COMMITTEE
Consultants
Borough Chairmen (5)
Resource Members (5)
Task Group Chairmen (11)
General Studies Chairmen (5)
Special Studies
Rehabilitation Facilities
Voluntary Health Agencies
Bronx
Brooklyn
Manhattan
Queens
Richmond
CBVH
DVR
NYCRIRC
Designee of the Mayor of New York City
Federal-State Operations
Blind and Visually Handicapped
Auditory-Speech
Heart, Cancer, Stroke
Emotional Handicaps
Mental Retardation
Socio-Medical
Arthritis
Respiratory Handicaps
Trauma and Orthopedics
Neurology
Additions-Alcoholism
Narcotics
Funding
Labor-Industry
Legislation
Manpower
Research
Correction, Parole, Probation
Social Services
Education

Regional Executive Committee

The Regional Chairman, Vice-Chairman, and the Assistant to the Chairman were members of the committee. Of the five Borough Chairmen, only those from Manhattan, Queens and Richmond participated in committee deliberations. The Chairman for Brooklyn was never designated, and with the resignation of the Bronx Chairman early in the planning effort, no replacement was made.

Five Resource Members were appointed of whom two were specified in the State guidelines: the designees of of the Commission for the Blind and Visually Handicapped and the Division of Vocational Rehabilitation. Others were from the New York City Regional Interdepartmental Rehabilitation Committee, a member with experience in federal-state rehabilitation programs, and the designee of the Mayor of the City of New York who accepted appointment as Honorary Regional Chairman.

In a further departure from the guidelines, the committee included five General Studies chairmen whose areas of interest were in Funding, Labor-Industry, Legislation, Manpower and Research. Eleven chairmen or co-chairmen of the Disability Task Groups were also assigned places on the committee.

Two consultants to the Regional Executive Committee were designated for their knowledge of rehabilitation facility operations and the voluntary health agencies. A total of 29 persons comprised the Regional Executive Committee of whom two were consultants. Staff support was provided by the New York City Regional Planning Director and the Regional Secretary.

Regional Advisory Committee Task Groups

As the Chart shows, eleven Disability Task Groups were organized, with members of the Regional Advisory Committee either volunteering or accepting assignment on one or more of them.

Dissatisfaction with the emphasis on categorical disability arose at the first meeting of the committee in December 1967. An attempt to unify some of the disabilities into more generic categories was not wholeheartedly accepted. A suggestion to combine emotional handicaps with mental retardation was rejected, although one joint meeting did take place. Similarly, the linking of Trauma and Orthopedics with Arthritis was not accepted. A category of Communications Impairment combining the Blind and Visually Handicapped with Auditory Speech Handicaps was not feasible because of the dissimilarity of the groups under study.

While the structure of the Disability Task Groups preserved the categorical focus, this held more as a frame of reference and procedural device than it did as a guideline to substance. Without exception, the Task Group Reports stated the problems within the particular disabilities, and then reached out to the larger arena of disability, per se. What resulted was a predominant concern with the handicapped person's functional capacity rather than exclusive preoccupation with specific needs of one or another disability. That initial dissatisfaction with structure may well have set the tone for the entire planning process.

Special Studies Task Group

Corrections-Probation-Parole, Education, and Social Services were viewed as part of a larger social system, organized to deliver a variety of services to answer varying client needs. Practitioners in each field were invited to participate in a study that would answer a basic question: for each field, how can vocational rehabilitation best be utilized?

Although this Special Studies Task Group met frequently, it did not issue a final report, but discussions indicated that vocational rehabilitation was a most desirable service that could be introduced into ongoing programs offered by other governmental and voluntary agencies. An indication of need for vocational rehabilitation services in correctional institutions is contained in a position paper prepared for the Task Group by Dr. Francis De Bilio, Director of Rehabilitation, New York City Department of Corrections.

General Studies

As provided in the Handbook, major concern was given to vocational rehabilitation needs in each region of the state for financial resources, including problems in budget and finance; legislation, including a review of existing legislation as well as suggestions for changes in law and policy; manpower, dealing with staffing patterns and professional and sub-professional utilization and recruitment; research, including a description of currently identifiable projects as well as recommendations for additional projects. It was also decided to give attention to labor-industry potentials for the development of placement opportunities.

The General Studies group was assigned the role to either develop pertinent data in each field and to review pertinent recommendations submitted in the Task Group reports. The Manpower Committee met on several occasions and position papers were solicited from a number of professional consultants in rehabilitation-related fields.

Reports submitted were as follows:

Celia Benney, N.A.S.W.	Social Work
Joseph G. Benton, M.D.	Medical Manpower
Leonard Diller, Ph.D.	Manpower Needs in Psychology and Rehabilitation
Beatrice H. Hill and Caroline Weiss	Therapeutic Recreation Manpower
Harriet Tiebel, O.T.R.	Occupational Therapy Manpower
Marvin R. Wayne, Ph.D.	Rehabilitation Counselors

Other study groups did not meet regularly, but the Chairmen participated in Executive Committee meetings and in the review of the Regional Report.

FUNCTIONAL INTER-RELATIONSHIPS

Introduction

Cold statements of fact often serve to blunt any implication of human interaction or differences in professional and managerial points of view. In striving to reach the Quakerian "sense of the meeting," the Task Group Reports do not suggest the dynamic exchange of opinion between the participants, nor do they include the learning effect when cross-fertilization of different professional viewpoints occur. Yet, the exchange of insights and the occasional "argument," the rare embarrassment because of errors in the interpretation of protocol, all happened.

The content of the daily newspaper also played a role and entered into discussions and deliberations. The planning process did not take place in a vacuum. To planners for improved and expanded vocational rehabilitation services, mounting public assistance roles was a matter of grave concern. So were the riots in Watts, Newark and Detroit and so was the Kerner Report. Just as perplexing were the hearings on the inadequacies of municipal hospital service in the City of New York and the closing of the City's public schools. The escalating costs of the Vietnamese war and the cuts in the federal budget and curtailment of spending for needed health and welfare services had a more direct effect on planning. The excitement of the national elections and politics in general had their impact too.

In describing inter-relationships, it is fair to mention these other influencing factors even though each specific cannot be quantified or weighted. A careful reading of the Task Group Reports will show concern for a host of urban problems, and while there are only a few explicit references to these issues, the findings and recommendations contained in the reports are rooted in social relevance.

Thus, many factors entered into the deliberations of the Regional Advisory Committee and in shaping the product. What follows will illustrate briefly how the committee structure functioned.

Roles

It has been stated that the initial staff suggestions for organizing the committee's work were modified as several of the Task Groups began to work together.

In outline form are the following functions assigned to each structural component:

Executive Committee

1. Organize Regional Advisory Committee into functional committees.
2. Supervise administration of Regional Advisory Committee through the Regional Planning Director.
3. Review progress of functional committees.
4. Receive and review committee reports.
5. Direct the preparation of a Regional Report that integrates committee findings and recommendations.
6. Approve a final Regional Report.

Task Groups

1. Organize its scope of work and determine assignments and data needed.
2. Review areas of concern.
3. Prepare a report of its findings and recommendations.
4. Chairman serves as member of Regional Executive Committee.

Members of Regional Advisory Committee

1. Accept assignment on appropriate committee or task group.
2. Participate in defining the scope of committees' inquiry and developing a methodology.
3. Assist in preparation of committee report.
4. Approve or dissent to committee report and the final Regional Report.

Regional Planning Director

1. Act as Executive Secretary to Regional Executive Committee.
2. Confer with Regional Chairman in administrative matters.
3. Participate in meeting of all Task Groups.
4. Render needed staff support to Task Group Chairmen.
5. Undertake assignments as directed by the Regional Chairman and Vice-Chairman.
6. Serve as liaison between Regional Advisory Committee and other community organizations or rehabilitation-oriented agencies.
7. Submit necessary reports and data to Office for Planning for Vocational Rehabilitation Services and accept such other responsibilities as the Director deems necessary.

Rather than detail the operations of each specific Task Group, a statement generally applicable to each of them will be made.

Assessment of Task Group Function

At the first meetings of the Task Groups there was considerable discussion of the scope of work. The Handbook which had been distributed to each Regional Advisory Committee member ambitiously laid out areas to be covered. While the Task Groups had no quarrels with these suggested guides, the practical difficulties in getting needed data, the time required to make thoughtful written presentations for each category of concern proved to be insurmountable. There was, of course, criticism because of the unavailability of adequate research staff support. There were further complications when the Federal Guidelines were distributed. These tended to be even more comprehensive and detailed than the State material.

These factors were reflected in the Task Group minutes, and in February 1968 the Regional Chairman responded to the problem of coverage. A much simplified questionnaire was sent to committee members as described on Page 2, Preliminary Regional Report. The Task Group reports would follow the questionnaire, but without circumscribing the limits of any discussion. The questions were broad enough to include any subject Task Group members thought pertinent to the issue of planning for vocational rehabilitation services. A target date of April 1, 1968 was suggested.

Many Task Groups submitted preliminary reports in compliance with the questionnaire, and by September 1968, nine final reports were submitted to the Executive Committee.

In order to meet the Statewide deadline for the submission of the Preliminary Regional Reports by October 1968, the Regional Planning Director was instructed to develop a draft report. This was completed on October 25, 1968.

Further meetings were held by the Executive Committee in November, and changes and revisions in the findings and recommendations were made. In addition, the Executive Committee directed the distribution of the Preliminary Report to members of the Regional Advisory Committee.

At its meeting on April 25, 1969, the Executive Committee reviewed comments made by members of the Regional Advisory Committee. After discussion, certain changes in the preliminary report were made and a final regional report was unanimously approved.

While the Task Groups were essentially oriented toward solving problems both in their method of inquiry and in reaching conclusions, they were well-equipped to do so. The joining together of many people of rich and diverse backgrounds afforded a broad perspective. The fact that many Regional Advisory Committee members were unfamiliar with the theoretical and practical elements of vocational rehabilitation gave practitioners in the field an opportunity to orient the newcomers. In turn, they were challenged with searching questions making restatements necessary.

The Task Group findings, and this is reflected in the Regional Report, recognize that rehabilitation broadly defined has the potential for broader applications. Those from other disciplines likewise recognized that rehabilitation could be programmed in their own fields. How these applications could be translated into practical results were dealt with in the recommendations submitted.

It can be concluded that as a result of the interchange between Committee members, the importance of rehabilitation was more fully appreciated and traditions in the field brought under constructive scrutiny. Change affecting many agencies and individuals was suggested. At this point, one can predict that this sharing of views will have a stimulating effect on the future delivery of rehabilitation services. The impact of the collective planning effort has already begun to be felt in many ways.

Impact of Rehabilitation Planning

It is not possible to catalogue the full effect comprehensive planning might have on service delivery in the New York City Region. Even before the final Report is submitted, there are indications that it will have a far-reaching impact on the rehabilitation movement.

In the conduct of a review of vocational rehabilitation needs that would expand services, defects in the current pattern of services were revealed, administrative integration was suggested and concepts of disability were enlarged. Interestingly enough, the planning participants chose to regard their field of study as being rehabilitation in its broadest sense. This position is abundantly illustrated in the text dealing with "Improved Service Delivery." The potential for systematizing rehabilitation concepts so that they can become translated into administrative possibilities has been the underlying theme of the Task Group Reports.

In smaller ways some movement of significance can be attributed to this planning project. Two sources, at least, have played a valuable role in stimulating interest in and response to rehabilitation needs: individual members of the Regional Advisory Committee, who in the course of their usual activities, exerted some influence in making decisions, and the regional planning staff whose dual mission was the internal administration of the entire planning apparatus and establishing links with other individuals and agencies in the community.

A few illustrations are indicated:

- With the announcement of the Comprehensive Statewide Planning Project, several key organizations saw an opportunity to focus on rehabilitation. In March 1968, the Community Council of Greater New York convened a meeting of the rehabilitation community, and as a result, reactivated a rehabilitation committee. The Community Council Rehabilitation Committee is currently active and plans to review the Regional and Statewide Reports. Of interest is the fact that many of its members also serve on the Regional Advisory Committee.

- As a result of their involvement in planning, the Queens Task Group has opted to establish a permanent rehabilitation group that will survive the life of this project.

- The Regional Planning Director was invited to be a liaison representative to the New York City Regional Interdepartmental Rehabilitation Committee. NYCRIRC's role is set forth in the section dealing with Primary and Secondary Rehabilitation Centers. Presently, NYCRIRC is considering expanding its structure in order to play a more significant role in the coordination of rehabilitation services.

- Discussions among Regional Advisory Committee members about the need for services for epileptics involved the Institute for the Crippled and Disabled, the New York Chapter of the Epilepsy Foundation of America and DVR. ICD is now developing a grant application for funding to carry out this program.

- The untimely release of a Task Group report that called attention to the large number of mental retardates awaiting DVR services led to improved DVR procedures.

- Regional Planning staff has set the stage for further discussions centering around the New York City Regional Report recommendations with New York Metropolitan Regional Medical Program which is concerned with rehabilitation services for heart disease, cancer and stroke patients. Similarly, there will be a review with the New York City Community Mental Health Board's Mental Retardation Service.

-Regional Planning staff and the Community Council Rehabilitation Committee staff have held discussions with the Urban Design Group of the New York City Department of City Planning in regard to elimination of architectural barriers and transportation problems faced by the city's handicapped population.

-Regional Planning staff has had discussions with the Metropolitan Chapter of the National Rehabilitation Association which may lead to discussions of the Statewide and Regional Report at its meetings.

-The Regional Planning Director has participated in many rehabilitation-related conferences and has either addressed or been a panelist at several meetings.

Conclusion

With the submission of the Regional Report of Findings and Recommendations, planning for vocational rehabilitation services will actually begin. A substantial number of Task Group recommendations require technical analysis and further study. Obviously, they cannot be made operational at once and some will require further change and updating.

In recognition of the need for continued rehabilitation planning, with community involvement, a major recommendation calls for the establishment in the Division of Vocational Rehabilitation of a Bureau of Planning and that an advisory regional planning group be appointed. Not only has the Regional Executive Committee been concerned about implementation, so too have most members of the Regional Advisory Committee. Almost from the start, the critical question was raised, "How will our recommendations be implemented?"

The New York City community is not unfamiliar with comprehensive planning programs for other subjects. Many have been completed, some are underway and others will most likely be developed. But, from the beginning of this undertaking, a commitment was made that where the planners made recommendations which could be immediately put into effect by the Division of Vocational Rehabilitation and the New York State Commission for the Blind and Visually Handicapped, this would be done. Further, it was agreed that the recommendations adopted in the Statewide report would be included in the upcoming State Plan for the delivery of vocational rehabilitation services.

Nevertheless, community involvement in planning that leads to the shaping of agency policy and operations can become a constructive force in improving services to clients. By focusing on the need for adequate funding at federal, state and local levels, community support will make implementation more likely.

The trending witnessed in New York City points to the willingness of the rehabilitation community to accept a responsible role in future planning for rehabilitation services.

APPENDICES

APPENDIX A

NEW YORK CITY REGIONAL INTERDEPARTMENTAL REHABILITATION COMMITTEE (NYCRIRC) AND NEW YORK CITY'S PRIMARY AND SECONDARY REHABILITATION CENTERS

Introduction

Following a meeting of the Regional Executive Committee in January 1968, it was agreed that some information about the primary and secondary rehabilitation centers would be useful. As a result, a survey form was developed by the Regional Coordinator of the New York City Regional Interdepartmental Rehabilitation Committee and distributed to each center coordinator.[1]

The review which follows is the result of that survey. In addition, the New York State Department of Health submitted data on admissions to the five primary rehabilitation centers located in New York City. The approach used here was to use both sets of data. (Form SHS #2) The range of disabilities was also reported. The classification system (Table V) used for reporting is under review by center directors and coordinators. Uniform statistical reporting is also under review.

An open-ended question was asked: What are the major problems in providing vocational rehabilitation services in the community? What role can the rehabilitation centers play?

At the outset, it is necessary to qualify the data used. Because of variances in reporting by the center coordinators, the staffing patterns are not always uniform. In addition, the primary and secondary centers relate to other affiliations as can be seen in the appendix of this report. It was not always specified whether the data reported related to the hospital unit or included the affiliates. The same is true for the data on the volume of patients treated.

The purpose of this critical analysis is to determine how effectively the rehabilitation centers relate to community-based vocational rehabilitation services. Based on the raw data submitted, with allowances for disparity in reporting, several major problems are identified.

Since this is a staff report, no recommendations are offered. It is hoped, however, that some further study of the center system will be undertaken. Ninety-six percent of the patients admitted to the rehabilitation centers are not referred for further services after they are discharged.

Obviously, a closer look is warranted.

Roles of Primary and Secondary Rehabilitation Centers and New York City Regional Interdepartmental Rehabilitation Committee

"Early in 1961, a two-pronged program was instituted by New York State designed 1) to promote and support a statewide network of comprehensive rehabilitation centers, and 2) to bring about more effective coordination of all types of rehabilitation services for handicapped persons of all ages." (5)

The first objective was accomplished by regionalization. New York City became one of six regions in the State to which financial support would be offered to existing medical centers to establish comprehensive rehabilitation services through the employment of additional professional and supporting rehabilitation personnel. Vocational evaluation was included as an integral part of the hospital-based rehabilitation programs and is therefor of particular interest to vocational rehabilitation planning.

"New York City presented special problems of structure and organization, not only because of the size of its population and the large number and variety of its rehabilitation facilities, but also because it contained a multiplicity of medical schools (six, at the time the plan evolved, and seven as of this writing), each with one or more affiliated teaching hospitals. In recognition of this concentration, six of the twelve primary centers projected by the statewide plan were assigned to New York City. The original plan also called for three secondary centers to be designated within the city; this has since been increased to four, and may see an additional increase in the near future." (5)

Two types of centers were defined - teaching hospitals associated with medical schools would be defined as primary centers and receive annual grants of $50,000 (NYC Region $40,000). Expanding hospitals or medical centers would be designated as secondary centers and receive annual grants of $35,000.

---

[1] The interpretation of the data and responsibility for its presentation rests solely upon the staff of the NYC Regional Office for Planning for Vocational Rehabilitation Services. The role of the centers and NYCRIRC was prepared by Miss Florence Stattel, Regional Coordinator, NYCRIRC.

Locally, the program is administered by the Bureau of Medical Rehabilitation of the New York State Health Department in cooperation with the New York City Regional Interdepartmental Rehabilitation Committee's Regional Rehabilitation Services Coordinator. The committee recommends priority for centers to be selected in the region. Monthly meetings with center coordinators and periodically held meetings with center directors along with quarterly statistical reports relate the centers to the central rehabilitation Coordinating Office. Both primary and secondary rehabilitation centers provide in-patient and out-patient rehabilitation services. The State proposal that difficult cases be referred to primary rehabilitation centers attached to medical schools has not had widespread follow-through in the region.

The second objective - to bring about effective coordination of all types of rehabilitation services was to be accomplished through a central office of rehabilitation coordination.

"A further complication in New York City was that its internal municipal structure paralleled the State's in the sense that multiple city departments were engaged in one or another aspect of rehabilitation service. Like the State, too, New York City had an Interdepartmental Health Council, although its composition -- consisting of the City Departments of Health, Hospitals, Mental Health and Welfare -- was narrower than the comparable State body, which augmented these with four additional departmental components: Correction, Education, Parole and Labor." (5)

Weaving a clear path through these complexities took some time, but the formula finally developed for New York City made sense. Its principal elements were these:

1. Each primary and secondary center would have its own internal rehabilitation coordinator.
2. To achieve community-wide coordination, a central office — the New York City Regional Interdepartmental Rehabilitation Committee -- would have an allocation of 20 percent of each primary center's annual State grant. (The question of whether similar contributions would be required from the secondary centers was left open.) It was further envisaged that, because this central office would have to operate in close liaison with the municipal departments engaged in rehabilitation services, the City of New York would assume the responsibility for a salary of a staff member assigned to the liaison function.
3. To anchor NYCRIRC's twin lines of responsibility to State and City, the membership of its governing body would consist of local designees of the eight departments constituting the New York State Interdepartmental Health and Hospital Council, plus representatives of the respective State and City interdepartmental bodies would participate as liaison representatives.
4. Separate organizational channels would be set up for relationships between the coordinating office and the primary and secondary rehabilitation centers.
5. NYCRIRC's staff executive would be administratively responsible to the chairman of the New York City Interdepartmental Health Council.

   NYCRIRC under this formula completed four years of functioning by 1968 and completed a report entitled Regional Coordination and Planning in an Urban Setting. This was done to seek clues to future directions. It was also necessary to objectively look at the regional planning concept which was new in 1964 and now had four years of functioning.

   The report indicated that three goals have been reached:

   a. A firm foundation for future progress has been built during the past four years. Cooperation now exists among the rehabilitation center directors. Community rehabilitation problems related to rehabilitation facilities and services arise and the regional primary and secondary rehabilitation centers under the Statewide Plan have become a knowledgeable group that can move to recommend appropriate action or guidelines. Organizational changes at the State and City levels mobilized NYCRIRC efforts in drafting a proposal for a new blueprint with broader purposes and objectives to recommend to the State Health Planning Commission and its regional counterpart.

   b. Measurable success has been achieved in tying together some of the main threads which make up the city's rehabilitation services. Much work remains to be done. Inclusion of the social and vocational rehabilitation facilities and services in the coordinating effort have been limited. Continuous developing of improved medical and vocational rehabilitation agency dialogues needs to be established. The New York City Regional Office for Statewide Planning of Vocational Rehabilitation has with its task force activities stimulated an atmosphere for improved dialogue.

c. NYCRIRC has clearly demonstrated its role as an action oriented resource for creative coordination and planning. Its role could be expanded if continuous budgetary support was forthcoming from the DVR to strengthen the social and vocational rehabilitation threads to the community. Further cohesiveness should develop in planning if the existing NYCRIRC primary and secondary rehabilitation structure is utilized by vocational rehabilitation as a natural link to rehabilitation services. Vocational evaluation and counseling started in the hospital, needs to be strengthened. Vocational rehabilitation services should move hand in hand with rehabilitation medicine in returning a handicapped person to the context of his home, family and community. This is particularly true in cases of chronic illness when prolonged medical management is required to assure continuity of medical, social and vocational services.

Since NYCRIRC's origin, the State's DVR representative on the New York City Regional Interdepartmental Rehabilitation Committee has served actively in the capacity of vice-chairman, member of special sub-committees, as well as program chairman of the 1966 rehabilitation workshop. Close continuity and compatible working relationships were established with DVR at their request that NYCRIRC recommend priorities for vocational rehabilitation workshop grants. Furthermore, several primary and secondary rehabilitation centers have strengthened their prevocational evaluation and rehabilitation counseling areas through federal grant funds initiated and approved by the State DVR. New York City DVR counselors have met with rehabilitation center coordinators through central rehabilitation coordinating efforts to define problems in the delivery of service.

Preliminary steps in improved communication have taken place between DVR and the primary and secondary rehabilitation centers through the central rehabilitation coordinating office. Cooperation with the NYCRIRC and the DVR could bear improvement and strengthening through budgetary supports.

The NYCRIRC structure of primary and secondary rehabilitation centers has had more measureable success than the five regions outside of the city. It survived the dissolution of its parent City and State body and its members have continued to function with a State link to the State Health Planning Commission and a City link to the Health Services Administration. It has moved to include voluntary agencies as liaison representatives and has utilized community experts to broaden sub-committee representation. It has laid the groundwork to expand and extend vocational rehabilitation and to clarify, interpret and educate local officials and leaders on its soundness of practice and worth in independence to the handicapped individual, his family and the community.

The Survey

Each center coordinator was asked to provide the following information:

1. The number of personnel in each of the rehabilitation occupations on the rehabilitation staff.
2. The number of patients referred to other rehabilitation agencies.
3. The major agencies used by the center.
4. The major problems in providing vocational rehabilitation services in the community.
5. The role that rehabilitation centers can play to alleviate these problems.

The resulting data is presented in the following five tables and then analyzed in the subsequent text.

TABLE I

TOTAL FULL-TIME STAFF AND CLIENTS SERVED IN PRIMARY REHABILITATION CENTERS IN NEW YORK CITY
1967

Primary Centers	Number of Staff	Clients Served
Bellevue Hospital	95.5	2,617
Bronx Municipal Hospital	182.5	1,811
Columbia Presbyterian Medical Center	84	3,892
Downstate Medical Center (Kings County Hospital)	140	4,416
Metropolitan Hospital	61.5	2,714
TOTALS	563.5	15,450

There does not appear to be a direct relationship between the size of staff and the number of clients served.

The make up of the staff in terms of occupational groupings appears to be consistent among all the centers, including the secondary centers. There are greater numbers of the traditional hospital personnel than social work and vocational counseling staff. The primary centers have much larger staff's than the secondary centers.

TABLE II

DISTRIBUTION OF STAFF BY OCCUPATION GROUP PRIMARY AND SECONDARY REHABILITATION CENTERS NEW YORK CITY.

	Phys.	Nurse	Occup. Ther.	Phys. Ther.	Social Worker	Psychologist	Recr. Ther.	Speech-Hearing Ther.	Voc. Rehab. Couns.	Total
PRIMARY CENTERS										
Bellevue Hospital	28	33	7.5	12	3	4	3	1	4	95.5
Bronx Municipal	29	59.5	24	44.5	7	2	3.5	5	8	182.5
Columbia Presbyterian Medical Center	20	16	9	34	2	1	0	1	1	84
Downstate Medical (Kings County)	30	49	15	21	4	2	11	3	5	140
Metropolitan Hospital	9	23.5	6	13	2	3	2	2	1	61.5
SECONDARY CENTERS										
Mount Sinai	6	0	6	10	0	0	0	0	2	24
Queens Hospital	3.5	0	12	17	2	2	6.5	3	3	49
St. Vincents Medical Center of Richmond	1	1	1.5	6	2	0	0	1	0	12.5
PRIMARY CENTERS	116	181	61.5	124.5	18	12	19.5	12	19	563.5
SECONDARY CENTERS	10.5	1	19.5	33	4	2	6.5	4	5	85.5
ALL CENTERS	126.5	182	81	157.5	22	14	26	16	24	649

The nature of staff complements by occupational grouping does not appear to be related to the number of clients served. Nor does there appear to be a direct relationship between the size of staff, staff complements, clients served, and the number of clients referred to other rehabilitation agencies.

TABLE III

NUMBER OF CLIENTS SERVED AND REFERRALS TO OTHER REHABILITATION AGENCIES BY PRIMARY REHABILITATION CENTERS NEW YORK CITY

	Clients Served	Referrals Total	Referrals DVR
ALL PRIMARY CENTERS	15,450	616*	409
Bellevue Hospital	2,617	254	74
Bronx Municipal Hospital	1,811	52	44
Columbia Presbyterian Medical Center	3,892	19	15
Downstate Medical Center (Kings County Hospital)	4,416	200*	200
Metropolitan Hospital	2,714	91	76

*Downstate Medical Center recorded DVR referrals only.

TABLE III-A

REFERRALS TO OTHER REHABILITATION AGENCIES BY SECONDARY REHABILITATION CENTERS NEW YORK CITY

	Referrals Total	Referrals DVR
ALL SECONDARY CENTERS	146*	113
Mount Sinai	101	78
Queens Hospital Center	35	25
St. Vincent's Medical Center of Richmond	10*	10

*St. Vincent's recorded DVR referrals only.

Approximately 4% of all clients served by primary rehabilitation centers were referred to other agencies. Two-thirds of these referrals were to DVR. However, 77% of all secondary center referrals were to DVR. All of the centers listed DVR as a major agency for referral for post-hospitalization or concurrent services for their clients. In New York City, where there is the highest concentration of rehabilitation programs and facilities (28 agencies sponsor workshops alone) in the state, only 15 agencies were reported as major agencies used for primary and secondary rehabilitation clients. (DVR was the only source listed by St. Vincent's on Staten Island.)

TABLE IV

NUMBER OF PRIMARY AND SECONDARY CENTERS REFERRING TO MAJOR REHABILITATION AGENCIES

Major Rehabilitation Agencies	Number of Centers Referring Total	Number of Centers Referring Primary	Number of Centers Referring Secondary
Division of Vocational Rehabilitation	8	5	3
New York State Employment Service	5	4	1
Neighborhood Youth Corps	1	1	
New York City Division of Employment Rehabilitation	1	1	
ALTRO	3	1	2
Association for Retarded Children	1	1	
Brooklyn Bureau of Social Services	1	1	
Brooklyn T.B. and Health	1	1	
Bulova School of Watch Making	1	1	
Council Workshop	1	1	
Federation Employment and Guidance Service	4	3	1
Federation of the Handicapped	4	3	1
Institute for the Crippled and Disabled	2	2	
JOB (Just One Break)	3	2	1
Queens T.B.	1		1

TABLE V

SAMPLE STUDY OF ADMISSIONS TO PRIMARY REHABILITATION CENTERS IN NEW YORK CITY BY DISABILITY 1967

DISABILITY	
Hemiplegia or CVA	1,708
Paraplegia	173
Quadriplegia	82
Amputation	841
Back Problem	532
Arthritis-Bursitis	1,149
Speech-Hearing	263
Cerebral Palsy	321
Cardiac	117
Poliomyelitis	90
Guillian Barre	26
Muscular Dystrophy	120
Multiple Sclerosis	133
Parkinsonism	200
Congenital Anomaly	227
Convulsive Disorders	14
Burns	117
Other Injuries (fractures)	3,133
Other neuromuscular or skeletal disorders	1,782
Respiratory	1,941
Other medical disorder	1,801
Other or unknown	600
Vascular	12
Peripheral Neuropathy	58
TOTAL	15,450

As a matter of interest, Table V shows the range of disabilities treated in the primary centers. This should be compared against incidence and prevalence figures for the region.

The area of investigation which was most revealing was that which dealt with major problems faced by the centers in insuring vocational services for their clients. Problems in transportation were a major concern. Many clients are unable to use public transportation facilities and find private carriers costly. For those clients who own cars, parking presents a problem. It was stated that these factors impede service delivery and cause many individuals who are ready for employment to remain at home and unemployed.

The centers reported reluctance on the part of industry to hire the handicapped and a lack of acceptance and understanding of the handicapped by the general public. In addition, one center reported that medical personnel lacked awareness of the needs and potential of disabled individuals and knowledge of rehabilitation programs available to fulfill this potential.

Several problems in the coordinated delivery system upon which the center concept is based were reported. Many clients require financial support or sponsorship to participate in a rehabilitation program. The waiting time for DVR pick-up of a case was viewed as a major obstacle to continuity of service. Poor communication networks among several agencies providing services to the same client result in either duplication or gaps in service. Other factors associated with these gaps are general manpower shortages and insufficient community programs and facilities.

Concerning the lack of community resources, several centers noted a lack of facilities geared for individuals who required long-term sheltered employment. This was a concern especially in finding placement for the elderly. Lack of sheltered rehabilitation programs for the alcoholic and addict were also noted. One center reported concern regarding DVR's hesitancy in accepting these two disability groups for service. An additional placement problem was the difficulty in providing industrial homework for homebound clients.

The following is a summary of recommendations presented by the reporting centers to remedy the problem now faced:

1. Have the primary and secondary rehabilitation centers become substations of the DVR District Office with a DVR Counselor as a member of the rehabilitation staff.

2. Expand the vocational program within the centers to include complete evaluation, personal adjustment training, vocational training, and direct placement service.

3. Encourage centers to handle sub-contract work within the expanded program.

4. Request the New York City Department of Hospitals to provide the legal clearance for clients to work in the hospital while in in-patient status.

5. Provide the center and/or voluntary agencies with funds to pay for client fees for service and other expense until DVR officially sponsors a case.

6. Authorize the center to become the liaison for rehabilitation agencies, public and private.

7a. Enhance community and industry understanding of the handicapped through a public education program sponsored by the centers.

b. Provide in-service training courses in rehabilitation for hospital personnel.

8. Develop a program of subsidized transportation with public funds for handicapped individuals beginning employment until they can afford transportation costs.

9. Plan for more sheltered employment facilities for the elderly and the severely disabled.

Analysis

The data and recommendations are best evaluated in light of the mission and goals originally assigned to the rehabilitation center program. The underlying principle was an appreciation of rehabilitation as a process beginning with disablement and continuing through employment, if possible. Rehabilitation requires an inter-disciplinary approach that requires readaption of traditional professional and organizational patterns.

On the state level alone there existed eight different departments responsible for related rehabilitation programs. The administrative profusion on the state and local level contributed to gaps in service, insufficient and late referrals, and shortages of personnel.

Rather than a redistribution of State Agency functions and responsibilities, coordination of services at the community level by the statewide regional coordinators working with the rehabilitation centers, appeared to be the solution.

> "The major function of the proposed centers would be to supplement the rehabilitation services rendered by public and private groups in the community and thus provide more effective services to programs administered either directly by State or by local government with State Aid. State and local governmental agencies would be strongly encouraged to refer their patients or clients to these centers." (1)

A regional coordinator attached to the primary and secondary center would ensure utilization of available resources in the community.

The hospital-based center was viewed as facilitating physician referrals to rehabilitation programs, encouraging the development of rehabilitation personnel training programs, providing a central focus for effective coordination of service programs, public and private, State and local. The goal of which was to serve a greater number of clients more effectively.

Conclusions

One result of the program, as this report illustrates, is that at present one more entity is involved in the morass of rehabilitation programs. The Center is confronted with and may contribute to the very problems it was designed to alleviate. Unfortunately, the statistical data does not provide any clues for remedial action. However, the fact that 96% of the center's clients are not referred to other programs underscores the concerns expressed by the administrators.

Obvious questions are raised as to whether or not the objective, "to bring about more effective coordination of all types of rehabilitation services for handicapped persons of all ages," has been realized. (See page 117) While the benefits of such coordination as has taken place are apparent in administrative areas, it appears that the program which has been operational in New York City for at least five years, has not yet had an appreciable impact on patient referrals to vocational rehabilitation agencies, or in persuading medical practitioners to refer patients to hospital-based medical rehabilitation departments or to the Primary or Secondary centers.

The report indicates that major questions must be answered before further action is taken. First, there must be an evaluation of the validity of the original concept upon which the program was developed. Second, it must be determined if primary and secondary centers, regardless of their expected role, are contributing to the total rehabilitation effort in a meaningful way. Once these two questions are answered then the recommendations of the centers themselves should be evaluated and other considered.

To make the determinations presented above, additional research is needed. Data in the following areas should be collected and analyzed.

1. How many clients served by primary and secondary centers are originally referred and/or sponsored by other agencies? Specifically, to what extent do State Agencies use the center?

2. How many of those clients referred by a center to DVR are then completely managed by DVR? How many are referred back to the center for case management with DVR only involved in financial support of services?

3. Of those clients discharged from the center program, how many go directly into employment? How many are placed directly by the center? How many are placed by SES?

4. How effective is the relationship between the secondary center and the primary center?

5. Are standards set for personnel accepted by all State managed programs? Are the standards realistic?

6. What are the coordinative problems of the Regional Rehabilitation Coordinator?

7. Does the New York City Regional Interdepartmental Rehabilitation Committee play a role in the administration of the program? Is it an effective role?

8. How many clients receive what kinds of vocational services in or through primary centers? Secondary centers?

9. With the growth of community psychiatry, what role can the center rehabilitation programs play?

REFERENCES

1. Organization Study of State Rehabilitation Services, Office of the Secretary to the Governor, October 1960.

2. Fenton, Joseph, Ed.D., "Interdepartmental Coordination of Rehabilitation in New York State Government," Rehabilitation Literature, Vol. 25, No. 4 (April 1964) pp. 98-104. Page 101 is of special interest.

3. Fenton, Joseph, and Martha A. Thompson, Eds., New York State Programs and Services in Rehabilitation. Prepared by the Governor's Council on Rehabilitation, Albany, N.Y. Revised April 1967. Chapter VI covers the Primary and Secondary Centers.

4. Akabas, Shelly, "Tax Supported Rehabilitation Services in New York City by Auspices of Provider and Source of Funds." The Urban Medical Economics Research Project, sponsored by Hunter College and New York City Department of Health, New York, N.Y., October 1962. This study gives an excellent review of some of the problems in physical medicine and rehabilitation services.

5. Stattel, Florence M. and Frances A. Koestler, "Regional Coordination and Planning in an Urban Setting," New York City Regional Interdepartmental Rehabilitation Committee, New York, N.Y., August 1968.

PRIMARY REHABILITATION CENTERS

A Primary Rehabilitation Center provides comprehensive rehabilitation services and is a part of a medical school and serves a highly populated region of the state. The center has inpatient and outpatient facilities and services.

ALBERT EINSTEIN COLLEGE OF MEDICINE
Department of Rehabilitation Medicine
Bronx Municipal Hospital - Primary Center
Pelham Parkway & Eastchester Road
Bronx, N.Y. 10461 TY 2-6000
Arthur S. Abramson, M.D., Director
Frances Shuff, Coordinator (X353)

STATE UNIVERSITY OF NEW YORK-DOWNSTATE MEDICAL CENTER
Department of Rehabilitation Medicine
Kings County Hospital - Primary Center
450 Clarkson Avenue
Brooklyn, N.Y. 11203 IN 2-4000
Joseph G. Benton, M.D., Director
Irving Kronenberg, Coordinator (X370)

NEW YORK MEDICAL COLLEGE
Department of Rehabilitation Medicine
Flower-5th Avenue Hospitals - Primary Center
5th Avenue & 105th Street
New York, N.Y. 10029 TR 6-5500
Julian E. Rosenthal, M.D., Director
Joseph Kramer, Coordinator (X136)

NEW YORK UNIVERSITY SCHOOL OF MEDICINE
Department of Rehabilitation Medicine
Bellevue Hospital - Primary Center
First Avenue & E. 27th Street
New York, N.Y. 10016 OR 9-5000
Bruce Grynbaum, M.D., Director
Terese Anastasia, Coordinator (X376)

COLLEGE OF PHYSICIANS & SURGEONS OF COLUMBIA UNIVERSITY
Department of Rehabilitation Medicine
Presbyterian Hospital - Primary Center
Broadway & 168th Street
New York, N.Y. 10032 579-2500
Robert C. Darling, M.D., Director
Mary Ellen Potash, Acting Coordinator (579-3041)

SECONDARY REHABILITATION CENTERS

A Secondary Center provides the same range of services as a Primary Center but may not be equipped to handle complex rehabilitation problems. The center has inpatient and outpatient facilities and services.
(Hospital underlined has been designated as secondary center)

Mount Sinai Medical Center
Department of Rehabilitation Medicine
100th Street & 5th Avenue
New York, N.Y. 10029 TR 6-1000
Lawrence Wisham, M.D., Director
Sam Chell, Coordinator (X317)

Long Island Jewish - Queens Hospital Center
Department of Rehabilitation Medicine
82-68 164th Street
Jamaica, N.Y. 11432 JA 6-8600
Andor Weiss, M.D., Director
Celeste Nodell, Coordinator (X193)

Misericordia - Fordham Hospitals
Department of Rehabilitation Medicine
600 East 233rd Street
Bronx, N.Y. 10466 OL 3-3000
Jerome Gristina, M.D., Director
Marvin Moss, Coordinator (X247)

St. Vincent's Medical Center of the Borough of Richmond
Department of Rehabilitation Medicine
355 Bard Avenue
Staten Island, New York 10310 442-5100
Milovan Rakic, M.D., Director
Arthur Nelson, Ph.D., Coordinator (X359)

Prepared by The New York City Regional Interdepartmental Rehabilitation Committee, 40 Worth Street, New York, New York
NYCRIRC: 1/14/68

The following hospitals are associated with the Primary and Secondary Rehabilitation Centers in one or more of the following ways: 1) Direct responsibility for rehabilitation care; 2) Medical supervision; 3) Teaching program; 4) Resident rotation; 5) Medical or team round; 6) Transfer of patients.

ALBERT EINSTEIN COLLEGE OF MEDICINE
- Bronx Municipal - Primary Center
  - University Hospital (Lubin Rehabilitation Center)
  - Lincoln Hospital
  - Montefiore-Morrisania Hospitals
  - Fordham-Misericordia Hospitals
  - Beth Abraham Hospital
  - Bronx V. A. Hospital

STATE UNIVERSITY OF NEW YORK - DOWNSTATE MEDICAL CENTER
- Kings County Hospital - Primary Center
  - University Hospital
  - Brooklyn-Cumberland Medical Center
  - Maimonides-Coney Island Hospitals
  - Jewish Chronic Disease Hospital of Brooklyn
  - Methodist Hospital
  - Long Island Jewish Hospital

NEW YORK MEDICAL COLLEGE
- Flower & 5th Avenue Hospitals
- Metropolitan Hospital
- Primary Center
  - Bird S. Coler Hospital

NEW YORK UNIVERSITY SCHOOL OF MEDICINE
- Bellevue Hospital - Primary Center
  - Goldwater Hospital
  - Institute of Rehabilitation Medicine
  - St. Vincent's Hospital - New York
  - Institute for Crippled & Disabled
  - Manhattan V.A. Hospital

COLLEGE OF PHYSICIANS & SURGEONS OF COLUMBIA UNIVERSITY
- Presbyterian Hospital - Primary Center
  - Harlem Hospital
  - Frances Delafield Hospital
  - Blythdale Hospital
  - NYS Rehabilitation Hospital, Haverstraw
  - Mary Harkness Convalescent Home

Mount Sinai Medical Center - Secondary Center
- City Hospital at Elmhurst
- Beth Israel Hospital
- Hospital for Joint Diseases

Long Island Jewish - Queens Hospital Center
- Queens Hospital Center - Secondary Center
  - Long Island Jewish Hospital
  - Mary Immaculate Hospital
  - Hillside Hospital
  - Meadow Park Nursing Home
  - Fairview Nursing Home

St. Vincent's Medical Center of Richmond - Secondary Center
- St. Vincent's Hospital - New York

Misericordia - Fordham Hospitals
- Misericordia Hospital - Secondary Center
  - Fordham Hospital
  - St. Patrick's Home
  - Providence Rest

APPENDIX B

REHABILITATION COUNSELORS

by Marvin R. Wayne, Ph.D.

Introduction

New York State is currently struggling with a serious problem in the lack of professional personnel needed to provide vocational rehabilitation services for 350,000 handicapped persons who could benefit from these services.

By 1975, the demand for qualified health personnel will be a serious problem on a national, state, and regional basis. In New York State alone the handicapped population that can be helped will be close to 600,000. This report will be limited to the specific need for rehabilitation counselors and will relate to the local needs of Region I (New York City).

Background

Since most of the available statistics relate to the national and statewide scene, it will be very difficult to give specific data for Region I. I will, therefore, briefly describe the problem as it exists nationwide and then try to relate to the needs of our immediate concern, Region I.

In 1965 it was estimated, on a nationwide basis, that in 1968 there would be needed at least 2300 new vocational rehabilitation counselors. In addition, over 300 additional counselors would be needed to replace those who terminate employment or retire each year. It should be noted that these estimates for vocational rehabilitation counselors deal only with State vocational rehabilitation agencies and do not include voluntary and other community agencies concerned with the rehabilitation of the handicapped. If the overall demand for vocational rehabilitation counselors was considered, the estimate would more than double. This means that by the year 1975, the total estimated need for new vocational rehabilitation counselors on a nationwide basis could well reach the 9000 figure.

Rehabilitation Counseling as a profession is thus rapidly approaching a critical period, demanding far-reaching and crucial decisions in the area of manpower development and utilization. The pressures of expanding vocational rehabilitation services to the disabled and disadvantaged groups, the anticipation of an unknown number of returned disabled veterans of the Vietnam conflict, the extension of services to groups of disabled persons less than optimally served, and, the development of new knowledge, are only a few of the factors contributing to the increasing need to reassess our present practices in professional education, staff development and manpower utilization.

State and Regional Projections for 1975

Based upon the figures estimated above by the 1965 Governor's Council on Rehabilitation Report, and other surveys, we can estimate that in 1975 New York State will need 600-700 new rehabilitation counselors to fill the personnel needs to provide vocational rehabilitation services.

This investigator conducted a sample survey in March 1968 of 19 major public and voluntary agencies in Region I. A questionnaire was sent out to ascertain the number of rehabilitation counselors currently employed and the projected number anticipated for 1975. The results are as follows:

Questionnaire sent out:	19
Responses received:	16
Percent of responses:	84
Number of counselors currently employed:	264
Number of counselors projected for 1975:	419
Agencies not able to predict for 1975:	3

It should be noted that there is no primary source available to determine the number of rehabilitation counselors available in any given area. There is no licensing or certifying body that can indicate the number

---

Professor Wayne, Coordinator of the Rehabilitation Counseling Program at Hunter College, served as a consultant to the Region I Task Force on Manpower.

of available counselors. This may be another area for future consideration and research.

On the basis of the limited survey, it is obvious that Region I is anticipating a doubling of the number of rehabilitation counselors it will need by 1975. This figure does not take into consideration the turnover of personnel nor the number of counselors that will be needed by the increased number of new workshops or programs that will be developed over the next seven years.

One other factor that is also important to consider is the great competition that is already obvious for the services of trained rehabilitation counselors. Many special research projects, anti-poverty programs, and the growth of counseling services within the public schools have already drained many trained rehabilitation counselors from the public and voluntary rehabilitation agencies.

Educational Resources

At the present time there are some 65-70 universities in the United States that offer graduate degrees in Rehabilitation Counseling. Seven of these universities are located in New York State, and three in Region 1.

In 1965, a survey of these programs was made by the Governor's Committee. At that time, Teachers College, Columbia estimated a graduate enrollment of 48 students by 1970, even though in 1966 they were at 100% capacity with 32 students. No expansion plans were indicated even though additional facilities were direly needed. Their program called for a two-year masters degree plus a doctoral program.

New York University in 1965, indicated an enrollment of 125 students, 93% of their capacity. 1970 estimates indicated no student increase even though N.Y.U. predicted that a 50% increase in enrollment could occur with additional staffing. N.Y.U. also offers a two-year masters and doctoral program.

Hunter College, the third school in New York City with a rehabilitation counseling program, offered a two-year masters degree program. It had an enrollment of 37 students. They were operating at only 60% of capacity due to the lack of students applying for matriculation. 1970 estimates indicate an increased enrollment to 52, depending on available students and funding for additional faculty.

The following data is taken from another of this investigator's surveys of the three local institutions.

A. Teachers College, Columbia University

1. Offers MA and Doctorate Program.
2. Graduating annually 40-50 MA candidates.
3. Graduates annually 5-15 Doctoral students.
4. Cannot predict to 1975 on basis of total program needs although major emphasis appears to be more toward the doctoral rather than the masters degree.
5. At full capacity now with 120 students. Without additional outside support for faculty and facilities, growth is unlikely.
6. Government grants (RSA) support about 50 students (42%).
7. 10% of graduates are placed in public agency programs. 90% of students are placed in voluntary and other related agencies. Very little is known about doctoral graduates in similar teaching institutions.
8. Due to oversubscription of students, no special recruitment techniques have been attempted.

B. Hunter College - (CUNY)

1. Offers MA degree only.
2. Graduates 10-15 MA students annually.
3. Difficult to anticipate number of 1975 graduates but probably 25-30.
4. It is anticipated that a doctoral program will be in effect by 1975.
5. At 60% capacity now but with additional staff and facilities (both contemplated within the next five years) could be at 100% capacity.
6. RSA grants support about 50% of current student load.
7. 26% of graduates are employed in public agencies and 56% of graduates are employed in private and related rehabilitation agencies serving the handicapped.
8. Extensive recruitment has been attempted to draw in more students, but to date it has been rather ineffectual.

C. New York University

1. Offers MA and doctoral degrees.
2. Graduating 30 MA students annually.
3. Graduating 6 doctoral candidates annually.
4. Anticipates 50 MA graduates and 10 doctoral candidates by 1975.

3

5. Currently operating at 79% of capacity with 138 students. They could accommodate 175 graduate and undergraduate students. With additional facilities and faculty, this number could be expanded.
6. RSA grants currently support about 36% of their students.
7. The placement of their graduates is divided equally between public and private rehabilitation facilities.
8. No special emphasis has been placed on recruitment procedures.

Only one program, Hunter, is anticipating any major building expansion by 1975. All three schools anticipate an increase of at least one faculty member.

It would seem that more intensive recruitment of students for the program would be beneficial to the undersubscribed programs at Hunter and in particular the undergraduate program at New York University. The latter's undergraduate program has not been emphasized to date mainly because the rehabilitation agencies today have not yet created a sufficient number of positions with their agencies to accommodate the placement of these bachelor degree graduates. Why train for jobs for which there are no openings available?

The coordinators of the programs are very much in accord concerning the value of work-study and paid internship experiences. They feel it would be a major step forward in recruiting new students. This approach is currently being seriously considered by the New York State Division of Vocational Rehabilitation. The continued support by RSA for more student aid in the form of traineeships, interim and summer employment, and the like, is vital if the programs are to continue their growth.

The coordinators also feel that higher salaries and, in particular, higher starting salaries would add to the recruiting of potential students. People work for money and will naturally seek out those positions which will benefit at the highest possible economic level.

Two specific problems that have a direct effect on the output of trained counselors are:

1. Removal of draft deferment for graduate students. This is sure to reduce the number of male graduates in the future and may result in a preponderance of females who will be graduated for the period of time in question.

2. The keen competition by other programs (social work, OEO programs, psychology, etc.) will certainly draw many good potential candidates away from enrollment in the rehabilitation counseling program unless some of the suggestions made above are incorporated.

A major concern of the universities today has been the pressures being brought to bear for the training of aides or sub-professionals. This is a problem that all colleges will have to face as the need to train professional personnel for the field becomes greater. This will certainly necessitate a new philosophy and approach on the part of many of the colleges for training students who might not normally be accepted for matriculation. This may necessitate a change in approach from formal academic training within the confines of the colleges to possibly more consultative services by the university faculty to the agencies for in-service programs. New York University has given some consideration to this problem and has made some inroads along these lines.

A review of the above data indicates that by 1975, the three university programs could produce, at the maximum, 145 graduates per year. At the present time no more than 91 students are being graduated. This would be an increase of only 50 graduates, or about 30%, by 1975. On the other hand, as noted in the previous section, an increase of over 50% is anticipated in the need for new rehabilitation counselors in Region I. It is quite evident, then, that the three area colleges will not be able to produce the required number of rehabilitation counselors to meet the needs of the Region even under the best of conditions.

What other potential educational facilities or programs are available in Region I that can be utilized to produce the needed trained personnel, aides or sub-professionals? Let us now turn to the possible use of undergraduate or two-year college facilities.

In 1965 a review was made of undergraduate programs and programs leading to the two-year Associate of Arts degree, to determine the feasibility of a "core" curriculum within the college or junior college for students who might eventually enter the graduate school programs. The conclusion was that at that time it was not being done, but with creative planning, forms of "core" curriculum were possible.

It was also determined that the two-year colleges were capable of assuming a very real role in alleviating the shortage in rehabilitation fields. This could be done by establishing agreements with colleges and universities on the course work which would be acceptable for transfer and also by listing the rehabilitation professions as potential fields of study for those who wished to continue beyond the two-year college level.

We can make some observations despite the limited data and time at our disposal to prepare this report:

1. It is extremely difficult to adequately project our data to 1975 for the reasons stated above.

2. It is very difficult, if not impossible, to consider an area, like New York City, and say these are the needs of Region I. The mobility of the students and the counselors is so great that even if we can provide enough counselors, the job movement upward and outward would prevent us from giving valid projections. All we can say is that we will not be able to produce enough trained counselors for our Region as long as the state and nation are in need of counselors. In reality, New York City is a training ground for personnel who may end up in Malone, New York or Butte, Montana.

3. The surveys indicate that effort is needed to encourage students to enroll in existing programs in public and private institutions which are undersubscribed.

4. There is a need for more programs and for the expansion of the facilities and faculties devoted to rehabilitation counseling education.

5. Even if fully utilized, the existing programs could not supply enough graduates to fill the present and projected needs.

6. It is not likely that any predicted expansion could flood the market with a sufficient number of personnel in the foreseeable future.

7. If we are to achieve even a modicum of success in meeting the stated needs, the universities and the agencies will each have to show a willingness to give a little and be more accepting of each other's goals, needs, and standards. To say the least, each will have to show more flexibility in arriving at obtainable goals.

8. There has been and continues to be, a great problem in "communication" between the providers and consumers. This also exists among the groups themselves. Until we can really learn to communicate our needs, not much is really feasible. This calls for more coordination, cooperation, and innovation among the professional groups involved. There is currently, a paucity of any of the above stated components.

RECOMMENDATIONS

Based upon the data presented, I would like to offer the following suggestions or recommendations that could eventually aid in the meeting of our needs for vocational counseling personnel in rehabilitation. Some of these could be achieved in short-term programs while others could be accomplished only over a long period of time. Some of these recommendations would also necessitate a new philosophy or approach in the training of rehabilitation counselors. Some are controversial and others are not. However, unless we are pragmatically willing to attack our problems, we will be meeting again in 1975 to repeat our present task.

A. Utilization of Personnel With Varying Degrees of Competency

1. Differential use of staff trained at the graduate level and of staff with less training
2. Classification of client needs
3. Separate career ladders for vocational rehabilitation
4. More undergraduate and two-year college preparation
5. Use of volunteers
6. Utilization of part-time employees

B. Effective Manpower Utilization

1. Manpower management
2. Use of group techniques
3. Improved personnel practices
4. Higher salary levels
5. Hire graduates of rehabilitation counseling programs when they are available (June, September and January)
6. More and greater use of trained clerical staff
7. Greater inter-agency cooperation

C. Staff Development

1. Strengthen the professional role of the counselor ("Image" is important.)
2. In-service training
3. Stimulate interest, change attitudes, and provide for professional growth

4. Increase agency-university relationships:
   - Develop work-study programs
   - Provide for paid internships
   - Set up summer and part-time work experience
   - Develop training centers for new counselors for orientation purposes
   - Sponsor more institutes and workshops
   - Extension and correspondence courses
   - Emphasize more formal academic training
   - Provide seminars

D. Graduate Education Development

1. Make the graduate school administrators more aware of the need to expand the programs.
2. Facilitate entrance into the graduate programs in rehabilitation counseling, e.g. shorten time to process applications, etc.
3. Increase the supply of doctoral trained personnel to staff the increasing number of new graduate programs in rehabilitation counseling as well as to aid in the expansion of the already existing institutions.

E. Use of Sub-Professional Workers

1. Train and supervise sub-professional workers in those techniques which do not require professional judgement and knowledge.
2. Draw these people from OEO and anti-poverty areas.
3. Investigate what other disciplines and agencies are accomplishing in organizing such groups and programs.
4. Analyze the job of the vocational rehabilitation counselor and describe those factors that can be done by other than trained counselors.

F. Recruitment

1. The state agencies should try to improve their image and determine why the majority of graduates enter private and voluntary agencies.
2. Increase salaries, improve work loads and working conditions.
3. More flexible salary differentials at the entry level to provide for previous experience (comparable to "step" of teachers).
4. Universities should be more flexible in their course scheduling to meet the needs of the part time students.
5. State agencies should do the same.
6. Provide a career ladder for advancement and promotion for vocational rehabilitation counselors.
7. Increase the number and amount of RSA grants for training (consider dependents on MA level).
8. Universities should give more consideration to the development of undergraduate and two-year college programs in rehabilitation education.
9. Agencies, universities and professional associations should do more and cooperate more in recruiting graduate students.
10. New, as well as already existing programs should be supported.
11. See recruits from the rehabilitation client group.
12. Seek out the mature women who would like to return to work after being trained and having already raised their families.
13. Look to the Peace Corps graduates for recruitment.
14. Develop and make more use of recruitment material (poster literature, etc.). The "Madison Avenue Approach" would be quite helpful.
15. Make the public and the legislatore more aware of what rehabilitation has accomplished and what is yet to be done. Let the public know what we can do and what is yet to be done. Let the public know what we can do and have already accomplished.
16. Recruitment for the health fields should occur early, beginning in high school whenever possible.
17. Seek out and publicize our programs to servicemen before they are separated from the service.
18. Attempt to reach the training schools of other rehabilitation disciplines for program drop-outs or rejectees who might find rehabilitation counseling is really what they have been seeking. A program that is already filled should suggest related programs that are under-subscribed.
19. Retired or pensioned city, state, or federal employees seeking more satisfying work are a good source for recruitment.
20. If professionally trained counselors are not available, attempts should be made to interest other related and experienced workers to move into rehabilitation counseling. I refer here to a potential group of 115 Social Security Disability Examiners in New York City who are trying to establish a career ladder from a "dead end" position. Their expertise in the

medical and vocational areas, plus a masters or the credits in counseling techniques could provide a "shot in the arm" for current Region I shortages in rehabilitation personnel. Other potential areas might include:
- employment counselors
- personnel workers
- probation workers
- Workmen Compensation counselors
- school teachers
- people with industrial experience for the workshops

There is no doubt that there will be an uphill fight to meet our personnel needs. It takes a long time for the turtle to cross the finish line, so, unless we atart the race now, it will be the handicapped client and not the turtle who will come in last.

Agencies and Institutions Surveyed

Educational Institutions:

- Hunter College of the City University of New York
- New York University
- Teachers College, Columbia University

Rehabilitation Agencies:

- A H R C Workshop
- Altro Workshop
- Brooklyn Bureau of Social Services
- Department of Hospitals
- Federation Employment and Guidance Service
- Federation of the Handicapped
- * Fountain House
- Industrial Home for the Blind
- Institute for Crippled and Disabled
- * Institute of Rehabilitation Medicine
- Jewish Guild for the Blind
- Montifiore Hospital
- New York League for the Hard of Hearing
- New York Commission for the Blind (VRS)
- New York State Division of Vocational Rehabilitation
- * New York State Workmen's Compensation
- Queensboro Tuberculosis and Health Association
- The Lighthouse
- U.C.P. of Queens

* Did not respond to Questionnaire.

REFERENCES

1. Fenton, J. and M. Thompson, eds. New York State Programs and Services in Rehabilitation: Background for the Development of a Comprehensive Plan for Rehabilitation in New York State, Prepared by the Governor's Council on Rehabilitation in Cooperation with the Committee on Rehabilitation of the Interdepartmental Health and Hospital Council. Albany, New York: 1967

2. Goerke, L. S., "Utilization, Recruitment, and Training of Health Manpower," American Journal of Public Health, Vol. 53, No. 10, (October 1965)

3. Guidelines for Action: Increasing the Supply of Qualified Rehabilitation Counseling Personnel in State Vocational Rehabilitation Agencies, Department of Health, Education and Welfare, Vocational Rehabilitation Administration, Washington, D.C.: 1966

4. Hutchinson, M.K., Effective Use of Health Manpower in the Community, Cornell University, Ithaca, New York: 1966

5. Increasing Manpower for Rehabilitation: First Step in the Development of a Comprehensive Plan for Rehabilitation in New York State, A Report to Governor Nelson A. Rockefeller from the Governor's Council on Rehabilitation. Albany, New York: 1965

6. Kissick, W. L., "Health Manpower for the Future," National Symposium on Health Careers, Detroit: 1965

7. Smits, S. J., ed., Rehabilitation Counselor Recruitment Study: Final Report, National Rehabilitation Association, Washington D.C.: 1964

APPENDIX C

REHABILITATION NEEDS IN QUEENS

Recommendations of the Queens Committee on Vocational Rehabilitation Services Planning

September 1968

Vocational rehabilitation including medical, social, and educational services has proved its ability to help handicapped individuals to much more productive and satisfying lives. To date, however, rehabilitation in Queens and elsewhere has reached only rather small numbers of people.

Queens has over 2,000,000 people. Over 50,000 have major limitations on activities due to chronic conditions. If we assume a disability rate of 9%, Queens has about 175,000 disabled persons. If we estimate that only 10% to 20% of this 175,000 need rehabilitation services, then 17,500 to 35,000 need help. A disability rate of 9% is very conservative when we consider that 1 out of 5 children in the United States are believed to have a chronic illness or defect.

In addition, the Task Group on Socio-Medical Handicaps has estimated that 67,618 persons in Queens have minor health problems which, accompanied by educational, social and cultural problems, present a substantial handicap to employment. Of this 67,618 the Task Group estimated that 13,523 could benefit from vocational rehabilitation services.

In contrast to these estimates of people disabled and needing help, we have only to take a few examples to see that the needs of great numbers of people are not being met. In 1967 the Division of Vocational Rehabilitation served throughout New York State 28,000 people, which may be just about the number in Queens needing help.

The vocational rehabilitation facilities of Queens serve at any one time approximately 300 to 400 people and possibly not even double that per year. Many more are served by the Division of Vocational Rehabilitation in trade and business schools, colleges and universities and through other resources, but still the number served is very low compared to those who need help. Most of the facilities feel they are underutilized, but they probably could serve only 600 to 800 without more space. THE PRESENT PUBLIC AND PRIVATE CASEFINDING, REFERRAL, AND SERVICE-DISPENSING SYSTEM URGENTLY NEEDS EXPANSION AND REORGANIZATION SO THAT SERVICES AND FACILITIES, BOTH EXISTING AND FUTURE, WILL BE MORE FULLY AND EFFECTIVELY UTILIZED. MANY MORE PEOPLE MUST BE PROCESSED THROUGH THE FACILITIES, SCHOOLS OR OTHER RESOURCES AND PROGRAMS TO ASSURE REHABILITATION WHICH IS TRULY AT THEIR HIGHEST POTENTIAL.

The Queens Committee endorses current trends to broaden the concept of disability to include not only the conventional physically, emotionally or mentally handicapped but also the socially disadvantaged. Some individuals from this large group have been previously serviced by qualifying them under already existing criteria, but there is no question that more socially disadvantaged could become acceptable for vocational rehabilitation with the establishment of such a category. It is also conceivable that by directing these clients through the longer established and standardized programs that better results might be achieved. At least those clients who need counseling, casework, psychiatric aid, and so forth might be identified more readily and prepared for vocational training which now is not working out successfully.

However, before the existing Queens agencies can be designated as more suitable resources, we recommend that some self-examination, interchange of principles and practices, and revamping and retooling of existing programs come first. The accrual of the information for this report has made this Committee aware that further study and factfinding is necessary.

Nevertheless, there is a vital need to proceed on the basis of the data currently available and to establish a format for future operations based upon experience and judgment. It is the firm belief of the Queens Planning Committee that we should not — we cannot — stand by and await the outcome of further and continuing studies.

The most urgent recommendation made in this report revolves about the establishment, in the very near future, of a "QUEENS REHAB CENTRAL." The establishment of such a facility, described briefly herein, could be initiated as a pilot project to develop a pattern of operations which could be proven in Queens and would hopefully be useful elsewhere.

The accumulation of information, its evaluation, and the development of programs and plans on the basis of such evaluated information is a continuing process. Conclusions are subject to adjustment to face the facts which appear the day after publication. It is therefore urgently recommended that, although a system of continuous study is proposed, action on the specific proposals be initiated now and funded through available government sources. We must recognize that increases in service and improvement in their quality will depend more upon experience and judgment in interpreting available information than upon the "ultimate information," a goal which will never be reached.

The Committee has reviewed the accrued information and has attempted to outline it under two classifications: 1) services almost totally lacking in Queens, and 2) services substantially lacking. Proposals of our recommended solutions accompany each item.

Also appended to this report are the sub-committee findings. They are included not as a consensus, but to illustrate examples of the expressions and suggestions of rehabilitation personnel now working in Queens.

SERVICES ALMOST TOTALLY LACKING	PROPOSALS
I. Coordination of referrals to vocational rehabilitation services.	I. Better methods of finding and serving the disabled in Queens are needed.
A. Casefinding	A. A multi-handicap referral and information center in Queens (Queens Rehab Central - see details, p. 134)
1. Ability to communicate in view of language barriers	1. Provision for interpreters
B. Proper screening by personnel in all potential referring agencies and resources.	B. Decentralize Division of Vocational Rehabilitation to stations at key neighborhood areas and liaison assignment to agencies, hospitals, clinics and educational institutions.
C. Instituting services within a reasonable time.	C. Improve interagency knowledge by setting up a permanent rehabilitation committee to: 1. Self-educate, i.e., institutes, visits 2. Educate other professionals and the public
	D. Review and overhaul state and private agency methods of processing and funding. 1. Relegate non-counseling activities to sub-professionals and clerks. 2. Contract for services with agencies based on total costs of program rather than on a per client or per service fee basis. 3. Allow more agency participation in processing, planning and initiating services with Division of Vocational Rehabilitation liaison counselor review and approval. 4. More centralization to pull together many government departments, agencies, and divisions through a State Rehabilitation Department. More decentralization to neighborhood centers for better understanding, casefinding and more personalized service.

II. General information on rehabilitation services.	II. There is a need for those concerned with rehabilitation in Queens to know more about what exists and what is lacking.
A. Existing facilities B. Needs for expansion C. Demographic information	Under Queens Rehab Central set up planning and information body or committee.
III. Wider spectrum of employment opportunities.	III. There is a great need for improvement and expansion of employment opportunities for the handicapped and aged since even after extensive rehabilitation assistance many clients cannot find or hold suitable employment.
A. Long-term sheltered workshops with permanent employment for multi-disability group, i.e., blind, severely permanently impaired (emotional, physical, retarded).	A. Government support for public and private facilities.
B. Work for the homebound for those who can earn regular industrial rates, which is totally lacking.	B. Legislative and Division of Vocational Rehabilitation changes.
C. Semi-sheltered employment for those who will be able to meet competitive standards with some assistance.	C. Cooperation of industry, government and rehabilitation agencies needed. Tax abatement incentives, O.J.T.'s and community pressures suggested.
D. Private competitive industry.	D. 1. Careful planning of rehabilitation programs to guide clients into existing and potential job markets where shortages of personnel exist. 2. Incentive plans to industry. 3. Public relations work between rehabilitation field and industry. 4. Better training in placement for rehabilitation personnel. 5. Closer cooperation of rehabilitation agencies with New York State Employment Service Special Placement and assignments of liaison special placement counselors to agencies. 6. More training to upgrade those currently employed.
IV. Transportation system for disabled to facilities for services, jobs, social and recreational programs.	IV. Because of the size of Queens and the lack of adequate transportation, there is a need for improved transportation services. A. Financing a transportation pool or contracted services. B. Volunteer motor pools coordinated by Rehab Central. C. Tax deduction for special handicapped transportation utilized by employees. D. Parking facilities or special parking permits.

SERVICES SUBSTANTIALLY LACKING	PROPOSALS
I. Acceptance of public responsibility to provide major funding for all rehabilitation costs.	I. Private agencies have some responsibilities, but staffing and updating programs and increasing services are dictated by financial capability. Many programs remain "status quo" because of a limitation of private agency funds and the priorities for allocating them. A. Provision of program and expansion costs on annual contract between private agencies and the Division of Vocational Rehabilitation. (See Queens Rehab Central)
II. Effective interagency communication-inadequate regular interchange of information among all agencies concerned with rehabilitation in Queens.	II. Radical changes in the structure and function of existing agencies are required to overcome the communication and service gaps. A. Rehab Central. B. Decentralization of Division of Vocational Rehabilitation to include establishment of a district office in Queens, Neighborhood Centers and liaison assignments of counselors to rehabilitation facilities, hospitals and educational institutions. C. Immediate steps to improve communication and cooperative services via: 1. Local training institutes. 2. In-service training and provision for more, and more varied scholarships and fellowships. 3. Regular interagency staff conferences for information and education.
III. Innovations in services, techniques or methods.	III. Because of the dynamic population changes in Queens in the past decade, there is a widening gap between rehabilitation needs and services. A. Community study and planning. B. Interagency study to reevaluate, modernize and expand existing programs. C. Accrediting programs and certification of personnel based on the above. D. Remedial reading, academic programs including mathematics, high school equivalency, etc. to allow for fulfillment of educational potential. E. Utilization of consultants from various fields including art, architecture, engineering, law, labor, business, education, and data processing.
IV. Special Placement Services	IV. Because even clients who have received adequate rehabilitation services too often continue to have employment problems, improvement must be made in placement and follow-up services. A. Increase New York State Employment Service contact through liaison assignments to agencies.

			B. Longer follow-up of clients beyond one month, with resumption of services as needed. (possible function of Rehab Central)
			C. Encouragement of private placement facilities to expand services for all disability groups.
			D. Encouragement of industry to provide a wider spectrum of jobs for all disabilities.
			E. Improved training in placement techniques for all rehabilitation personnel.
			F. Planned relationship between training programs and the job markets of the future.
V.	**Lack of sufficient general funds in agencies especially for innovative or special services. A lack of simple, prompt, efficient methods of disbursing funds to the private agencies.**	**V.**	**Because of existing methods of obtaining and disbursing public funds, client services are limited and excessive staff time is absorbed in accounting for individual fees-for-services procedures.**
			A. Division of Vocational Rehabilitation contract with private agencies, payable quarterly, to provide needed funds for services without delay.
VI.	**Mental Hygiene Services** **Adequate psychiatric care, casework, family counseling.**	**VI.**	**Excluding Creedmoor State Hospital, Queens Aftercare Clinic and Hillside Hospital's specific needs about which we do not have enough information, there is a substantial lack of adequate mental hygiene services for rehabilitation clients.**
			A. Division of Vocational Rehabilitation should broaden the spectrum of casework and psychotherapy services.
			B. Study of existing social agencies to explore the reason for long delays or problems in providing services.
			C. Study to determine the need for more mental health services, their funding and staffing.
VII.	**Shortage of capable trained professional rehabilitation personnel.**	**VII.**	**Because there is need for recruitment of more young people into the field and the retention of capable, trained personnel, realistic changes must be made.**
			A. Pay scales, working conditions, and fringe benefits should be at least equal to the competitive fields of social work, teaching and school guidance.
			B. More recruitment in high schools and colleges.
			C. Use of case aides to relieve professionals of routine tasks.
			D. Development of career ladders to provide more opportunities for advancement in the state agencies.
VIII.	**Adequate vocational training for the mentally retarded is lacking, particularly in the age group 16-21.**	**VIII.**	**Only a small percentage of the mentally retarded in the educational and vocational training age brackets are receiving meaningful vocational direction.**

	A. Jointly supervised Board of Education and Division of Vocational Rehabilitation vocational training centers, properly equipped and staffed, should be located in each school district.
	B. Expanded use of the Work-Study Program jointly supervised and meaningfully geared toward productive employment in the future labor market.
	C. C.R.M.D. class curricula must be revised toward developing the full intellectual, vocational, and social potential of the mentally retarded.
	D. Close working relationship with earlier proposed long-term sheltered facilities to provide proper vocational opportunities for the severely retarded.
IX. Recreational facilities and programs for aged and handicapped.	**IX. Professional guidance and public education in the management of all types of recreation facilities to provide understanding of the need for recreational opportunities for the handicapped are essential as a basis for developing private and public facilities.**
	A. Legislation on liability coverage to protect providers of recreational facilities for the handicapped.
	B. Joint efforts with the American Institute of Architecture (and local groups and Architectural Barriers Committee) to devise means of overcoming architectural barriers.
	C. Joint efforts with Office of the Borough President of Queens to institute necessary procedures for establishing building standards to more amply serve the handicapped.

THE PROPOSED "QUEENS REHAB CENTRAL"

The proposed QUEENS REHAB CENTRAL is unique only in its combination of approaches and resources; every element involved therein has had acceptance in the past, and an intelligent application of these principles is the essential need for the future.

The concept involves the currently popular principle of a close partnership between the official and voluntary aspects of community service; it involves further, a "joining of hands" with mutual respect for each other's capacity and judgment, and a willingness for all concerned to surrender a small segment of their authority and autonomy in return for a vastly improved system of coordinated facilities serving the handicapped of the community.

QUEENS REHAB CENTRAL would be government-funded and controlled by a policy-making body including representatives of the official agencies, voluntary institutions and agencies, and the community.

Operation of QUEENS REHAB CENTRAL would be placed in the hands of experienced and professionally qualified staff people responsible to the policy board through an executive designated by that board.

The following would be areas with which the QUEENS REHAB CENTRAL would be concerned:

1. **Gathering and disseminating information on existing services**
2. **Review and evaluation of services**

3. Planning for borough-wide services- Planning with Division of Vocational Rehabilitation and other appropriate agencies to coordinate programs, avoid duplication, set priorities, recommend utilization of funds, personnel and other resources

4. Certification of rehabilitation personnel and accreditation of agencies

5. Training of professional and sub-professional personnel

6. Self-referral and professional referral

7. Casefinding

8. Services for the homebound

9. Half-way house for clients unable to return to their homes

10. Long-term sheltered workshops

11. Public education

As proposed, QUEENS REHAB CENTRAL would accumulate records on all persons requiring rehabilitation services and on all persons served, and the services rendered, in order to disseminate these to all involved agencies; the consolidated information would be the basis for the data necessary both for operations and future planning. The planning facet of QUEENS REHAB CENTRAL's total function can be characterized as its most important reason for existence.

Services rendered by the referral and services agencies to the handicapped of the borough would be supported by contract rather than a fee-for-service basis, on a formulation including funds for experimentation, growth, expanded training, and so forth.

Only accredited agencies with certified personnel would be eligible for contracts, assuring highest standards; the accreditation and certifying process would be linked closely to the processes of education, training and performance analysis.

The accumulation of information as a basis for planning, and the development of plans as a basis for service, as well as the services carried on by QUEENS REHAB CENTRAL provide both an opportunity and an obligation for the dissemination of information to all segments of the public including education and training of professional and sub-professional personnel. Education and training, as well as public information, would be direct concerns of QUEENS REHAB CENTRAL. Casefinding, self-referral and professional referral would be enhanced by public information.

QUEENS REHAB CENTRAL could exert a restricting as well as a developing influence by guiding available and planned resources into the most productive channels suggesting priorities and avoiding duplication.

The aim of this plan for QUEENS REHAB CENTRAL would be effective, efficient, economical service to all who are in need of rehabilitation.

It is envisioned that the availability of funds under Statewide Planning for Rehabilitation, possibly through a Research and Development grant, could make a reality of these proposals within a three-year period since much of the thinking on this matter has already been done and considerable discussion has taken place in connection with the review of the existing facilities and of the gaps between services rendered and services required.

QUEENS COMMITTEE FOR VOCATIONAL REHABILITATION SERVICES

Second Preliminary Report
On Referring Agencies

August 23, 1968

I. Background Information on Survey Upon Which Report is Based

A. A "preliminary survey" questionnaire was sent to the following 12 agencies during July and August of 1968:

1. Booth Memorial Hospital
*2. City Hospital at Elmhurst
3. Community Service Society
*4. Creedmoor State Hospital
*5. Hillside Hospital
6. Jamaica Hospital
7. Jewish Community Services
*8. Long Island Jewish Hospital
9. New York State Division of Vocational Rehabilitation
*10. New York State Employment Service
*11. Queens Aftercare Clinic
*12. Queens Hospital Center (Psychiatry)

B. Written or telephone replies have been received from all the above agencies, except the New York State Division of Vocational Rehabilitation. The agencies denoted by an asterisk (*) submitted substantial replies and provide the major content of the replies summarized below. The other agencies indicated that they had either too little data available or too little known activity in the vocational rehabilitation area, and therefore could not reply to most of the questions.

While some information was elicited from the intake files of the New York State Division of Vocational Rehabilitation, a full reply to the questionnaire was not solicited from them. It was felt that the Division of Vocational Rehabilitation is in a unique category and should give its own separate report to the Committee with regard to referral practices, related problems, and recommendations. Most vocational rehabilitation agencies are vitally dependent upon the Division of Vocational Rehabilitation for approval and subvention. The Division of Vocational Rehabilitation therefore represents the grestest single index of information about referral traffic, and probably exerts the greatest single influence, directly or indirectly, on the nature of prevailing vocational rehabilitation practices and procedures in the community.

C. There are at least ten additional agencies which are potential sources on referral services to Queens residents which were not as yet approached because of time limitations. These agencies may be surveyed at a later date if indicated.

II. Summary of Descriptive Information of Agencies Responding

A. Almost all the agencies designated by an asterisk above provide, in addition to referral services, one or more other vocational services intramurally. While the array of other services offered generally includes some form of evaluation, counseling, training and placement, there are wide differences in the nature and level of delivery of these services.

B. Only four of the agencies, all hospitals, have within the agency a physical area devoted specifically to vocational rehabilitation. Here again, the size of the area, equipment contained herein, and kind of activities varies greatly.

C. Only a small portion of the staffs within these agencies who are active in vocational rehabilitation functions actually have formal training in vocational rehabilitation. Most have either had fragments of training in vocational rehabilitation or related subjects, or have been trained within the agency itself. Almost the entire range of professional disciplines can be found as staff in vocational rehabilitation programs within the sum total of agencies, but occupational therapists and social workers are most prominently represented among the non-vocational rehabilitation trained personnel.

D. Most agencies do not keep statistical records of their vocational rehabilitation activities, so that very little specific quantitative data are obtainable. Most figures offered were based on rough, offhand estimates. With that limitation in mind, the following elicited data are summarized:

1. Based upon a scan of the Division of Vocational Rehabilitation's intake rolls covering the period from July, 1967 to July, 1968, a total of 996 referrals were counted from Queens alone. This is to be viewed as a very minimal figure for total annual referrals for Queens, as the above count does not include the many citywide agencies which serve Queens residents. Also not included in the count are referrals from agencies such as the Commission for the Blind and Visually Handicapped and the Veterans Administration, as they do not apply for Division of Vocational Rehabilitation subvention in many, if not most, of their vocational rehabilitation cases.

2. No agency felt able to measure the number of potential vocational rehabilitation clients who were not referred, but most presumed that there probably are a substantial number in that category who are not referred for the following reasons (in order of frequency mentioned):

   a. There are excessive waits until clients can start in vocational rehabilitation programs.

   b. The staff in the agencies, especially physicians, are not attuned to vocational rehabilitation principles and practices, and are often not knowledgeable about resources and procedures.

   c. Lack of adequate vocational rehabilitation services for some clients.

   d. Many clients stay in the agency for a short time, so that there is insufficient time and opportunity to evaluate their vocational needs.

   e. Staff in agencies often misjudge the criteria for referral, and tend to under-refer.

   f. Clients who need vocational rehabilitation service are often resistive to such help, and require a motivational influence.

   g. Many who need vocational rehabilitation service are isolated individuals unknown to community agencies.

3. There does not seem to be a clear, common pattern among the agencies with regard to which staff members are responsible for making referrals. Although almost all professional disciplines are represented within the total range of referrers, vocational counselors and social workers are mentioned most frequently among those who perform this function.

4. For reasons partly explained above, most agencies refer clients in need of vocational rehabilitation to the New York State Division of Vocational Rehabilitation. In most instances, the Division of Vocational Rehabilitation will eventually refer clients on to one of the many approved vocational rehabilitation centers in the community. The Division of Vocational Rehabilitation would therefore seem to be the best source for information as to which facilities are utilized, and to what extent, for Queens residents. To the extent that referring agencies sometimes select centers directly, the facilities mentioned most frequently were the Rehabilitation Institute, Altro Workshops, Fountain House, Federation Employment and Guidance Service, and the Postgraduate Center for Mental Health. Perhaps it is of some significance that less common reference was made to vocational rehabilitation centers located in Queens, e.g., Queens Cerebral Palsy Center, Queensboro Tuberculosis and Health Association, Queens County Rehabilitation Center and the Association for the Help of Retarded Children.

5. Only two agencies are receiving funds specially for vocational rehabilitation outside of the regular budget. One of these agencies receives $9,500 per annum from the National Institute of Mental Health. The other agency receives per capita subvention from the Division of Vocational Rehabilitation for vocational rehabilitation cases. None of the agencies had concretized their thinking as to the specifics of additional funds needed, but most indicated that funds could be utilized for more vocational rehabilitation staff. One agency indicated a need for additional space.

6. Only two agencies are currently engaged in some form of research with regard to vocational rehabilitation. One of these agencies is in the process of studying the effectiveness of beginning vocational rehabilitation service to adolescents as early as age 15 or 16. The other agency is studying the value of multiple family therapy in conjunction with vocational training. Both of these studies are funded by the Division of Vocational Rehabilitation.

III. Summary of Problems and Recommendations Expressed by Responding Agencies

A double asterisk (**) preceeds those points which were expressed by virtually all agencies. A single asterisk (*) denotes that more than one agency mentioned that point, but at least two or three fewer than all. No symbol is used where the point was made by only one agency:

A. Problems Within the Referring Agencies

**1. Agency staff, especially physicians, are inadequately attuned to vocational rehabilitation and they are not sufficiently knowledgeable with regard to vocational rehabilitation resources and referral procedures.

2. The task of educating agency staff is complicated by the turnover rate of staff in some agencies.

*3. There are insufficient vocational rehabilitation personnel within most agencies.

4. Referral agencies do not stress the need for direct vocational rehabilitation services within their agencies.

*5. The referral process begins too late in the course of the client's treatment within the referring agency, so that the process becomes a hasty and frustrating experience for the client and agencies.

6. There are procedures within certain agencies which limit the kind of vocational rehabilitation programs that can be offered, such as the "honor card" system in one psychiatric hospital which restricts the freedom of movement of many patients within the hospital.

**7. In view of the staff and organizational deficiencies with regard to vocational rehabilitation in many large referring agencies, it was suggested that funds and other kinds of impetus should be offered to develop and strengthen this structure within the referring agencies. This would be aimed at achieving greater emphasis on and earlier inception of the vocational rehabilitation process, better education of non-vocational rehabilitation staff regarding vocational rehabilitation, continuity of service to clients, more accurate and useful records of data, etc. With the location of more qualified personnel and more professional services within referring agencies, the vocational rehabilitation staff in the agencies should be authorized to make direct referrals to vocational rehabilitation centers without waiting for Division of Vocational Rehabilitation approval.

8. There are legal barriers to establishing work-for-pay programs within voluntary and municipal hospitals. These barriers should be removed, as such programs are desired in some of those institutions.

9. There has been a significant rise in the number of elderly clients who require some form of vocational rehabilitation.

B. Problems Within the Community

1. Probably because so much of the prevailing vocational rehabilitation activity is predicated on Division of Vocational Rehabilitation policy, the most emphatic and widespread dissatisfaction pertained to the Division of Vocational Rehabilitation system, as follows:

   **a. The screening process, and the time it takes until the client starts in training is much too long. This complaint was made of some individual vocational rehabilitation centers too, but much of the delay seems preferable to conforming with Division of Vocational Rehabilitation requirements.

   **b. The screening process is much too cumbersome: too many steps, too much information required, some duplication of effort.

   **c. Division of Vocational Rehabilitation liaison counselors are not sufficiently available to the agency.

   **d. Many clients need much more time than allowed by the Division of Vocational Rehabilitation, especially in training programs. For some patients, time limits are not appropriate but antitherapeutic.

   **e. The attitude and performance of Division of Vocational Rehabilitation counselors within the central office framework were subject to various criticisms: they are slow-moving, hard to reach by phone, don't readily respond to telephone messages, tend to favor some clients and neglect others, don't follow-up clients sufficiently, many don't appear adequately trained for job requirements.

f. Some of the schools approved for training are not suited to the rehabilitation of the handicapped, particularly psychiatric patients.

*g. In addition to the fervent hope that the Division of Vocational Rehabilitation will find the means of overcoming the above-cited problems, particularly the slowness of the process, several specific recommendations were expressed:

1) There is reportedly a two-month period set aside by the Division of Vocational Rehabilitation for the clerical closing of cases at Central Office, during which time services to clients are greatly stalled. The closing of cases should be distributed throughout the year to avoid any period of immobility.

*2) The Division of Vocational Rehabilitation should consider contracting out to the community agencies as many of its services as possible. Evaluations, goal setting, and direct referrals to vocational rehabilitation centers might be done most expeditiously within the referring agencies if vocational rehabilitation funds are made available for this purpose.

3) The Division of Vocational Rehabilitation should make it possible for patients to start training while they are still hsopitalized and be flexible in the schedule of hours so that various part-time arrangements would be possible.

4) Psychologists and social workers should be included in the Division of Vocational Rehabilitation panel for personal counseling.

5) Subvention rates to vocational rehabilitation centers should be increased by about $15 per week per client.

*6) More comprehensive and definitive follow-up services should be instituted, and significant data regarding individual clients and general trends should be disseminated to referring agencies throughout the year.

2. The various references made to difficulties encountered with regard to vocational rehabilitation centers included:

**a. The work experiences within the center is often not sufficiently realistic in terms of the real work world. More stringent efforts need to be made to stimulate real work conditions, including the elements of wages, products that are salable, and so on.

*b. The work which the client ultimately does in the real work market is often quite different from what the client was trained for at the vocational rehabilitation center. Work experiences in these centers need to be geared to the individual needs and capabilities of the client.

*c. Many clients cannot accept the postponement of a sufficient living wage until training is completed, and will therefore either resist entering vocational rehabilitation programs or will drop out prematurely. A minimally adequate wage or equivalent subsidy should be provided to clients in training.

*d. Clients receiving special forms of financial assistance, such as welfare and social security, are often reluctant and fearful of undertaking a training program or eventual job placement if, as a result of the new income, the other benefits are immediately reduced or eliminated. This reduces the personal incentive and is a threat to the security provided by the other benefits. It is therefore recommended that recipients of such benefits be permitted to keep their new income without loss of other benefits until at least ten months after continued employment. It was further recommended that vocational rehabilitation clients receive tax benefits as now applies to the blind.

*e. Many vocational rehabilitation centers have selection policies which tend to exclude some needy clients. More multi-handicap centers are needed.

**f. The geographic distribution of centers is such that there are severe travel difficulties for large segments of the population. Special transportation is needed, such as special vehicles for transportation discounts on public transportation fares for vocational rehabilitation clients.

**g. There is often lack of compatibility and continuity in service to the client between the vocational rehabilitation center and the referring agency (usually a clinical treatment agency). In response to this problem and that mentioned above, it is recommended that neighborhood vocational rehabilitation centers be established throughout Queens, and that these centers be tied in specifically with the large referring agencies in their respective areas. This would enhance the level of integration between vocational rehabilitation and clinical service, the continuity of service to the client, reduce the travel problems for the client, and keep to a minimum the number of agencies and staff involved in helping the client at any one time.

**h. Most vocational rehabilitation centers are mostly, or exclusively, transitional, time-limited programs. As indicated above, in relation to the Division of Vocational Rehabilitation, many patients may require long-term, non-competitive, sheltered work conditions. Extended sheltered workshops should be established, on a subsidized basis if necessary, for such clients. Such workshops should include work-for-pay, diversified and graded levels of work, and flexibility with regard to work hours and productivity expectations. The recommendation for extended workshops was one of the most unanimous recommendations made.

i. Financial solvency is such a major concern to vocational rehabilitation centers that it often appears to be the overriding factor in determining policy, programs and procedure. These centers should therefore be operated by the state or other governmental groups in order to assure that the needs of the client will not be overshadowed by financial concern.

*3. In addition to utilizing vocational rehabilitation centers, or perhaps to an even greater extent, efforts should be made to establish training programs and sheltered workshop conditions within regular industry. This would mean more intensive promotional efforts with individual employers and organized industry with the provision of subsidies to the employer when necessary. The government should mandate industry to employ a quota of the hard-core handicapped, as has been done successfully in parts of Europe. The employers should be expected to find ways of accommodating the disabled, rather than placing the entire onus of adaptation upon the disabled client. This type of focus would address itself to several aforementioned problems, including the need for maximally realistic training environments and the relative artificiality of vocational rehabilitation center settings. It may also obviate some of the difficulties in the placement process to be mentioned below.

*4. Many placed clients, upon graduating from training programs in schools and vocational rehabilitation centers, don't seem to hold their jobs. The placement and follow-up process needs to be more intensive to increase the likelihood of the client's remaining on the job and/or to scrutinize the reasons for failure.

*5. The placement process for some clients, particularly psychiatric patients, is complicated by restrictions placed on civil service job applications and auto drivers' licenses. The unduly cumbersome and discriminatory aspects of these procedures should be reviewed and modified.

*6. The following important supportive services are not sufficiently available:

   a. family counseling

   b. psychotherapy

   *c. residential shelters

7. A dearth of vocational rehabilitation services for the following categories of clients were mentioned:

   a. the controlled epileptic

   b. the homebound client

   c. the socially disadvantaged

   d. the hard-core clients (school dropouts, parolees, multi-problem cases)

*8. Liaison placement counselors from the New York State Employment Service should be based in major referring agencies along similar lines as the Division of Vocational Rehabilitation liaison counselors.

*9. A structured vocational rehabilitation process should be built into the high school system so that preparation may begin at the earliest possible time and prevent having to deal with the problem at a later stage when it is much more costly psychologically and practically to the client.

**10. The manpower shortage in the vocational rehabilitation field should be dealt with primarily by employing and training sub-professional aides. A major task of the smaller cadre of trained vocational rehabilitation personnel may be the training and supervision of the aides. Work-study opportunities should be provided to encourage and enable qualified aides to pursue more formal training in vocational rehabilitation. The more strategic distribution of vocational rehabilitation centers and personnel, as mentioned above, would also possibly effectuate a better deployment of existing trained personnel. Under present conditions, there is a certain amount of duplication in under-utilized services and no staff or facilities available for some services in demand.

11. The lay community should be involved to a much greater extent in the development of vocational rehabilitation services and facilities.

12. Along with the sparse amount of vocational rehabilitation research currently conducted by Queens agencies, there is also little prospect for more such activity in the near future. In fact, responses to the questionnaire upon which the report is based indicated that very little concrete thinking or planning has been done with regard to research that needs to be done. The suggestions for future research show a wide variance, to the extent that virtually no suggestion by one agency was duplicated by another. The suggestions consisted of the following:

   *a. The suggestion which came closest to being somewhat of a consensus had to do with a systematic follow-up of results and the gathering of fundamental data about what is happening in the vocational rehabilitation field, so as to pinpoint the strengths and weaknesses of current practice and decide on its implication for future action.

   b. Determine criteria for assigning the client to different services such as evaluation, personal adjustment training, sheltered workshop and placement (work readiness).

   c. Matching of job opportunities and work tasks with types of illness and/or personality.

   d. Investigate reason for high rate of job turnover.

   e. Establish work norms for the normal population against which to compare the handicapped, especially to make sure that we don't expect more of the handicapped than what the norms are.

   f. Determine techniques for helping the mentally retarded, and narcotic addicts or former drug users.

   g. Determine the kind of vocational rehabilitation preparation that can be afforded in the schools.

   h. Evaluate the comparative effectiveness of the group counseling versus the individual counseling method.

   i Evaluate the benefits of the specialized setting versus the generic handicap setting for psychiatric patients.

   j. Formulate a system of vocational rehabilitation diagnoses and prognostic criteria as apart from the clinical diagnosis and prognosis.

   k. Determine effective techniques for attuning clinical staff to vocational rehabilitation thinking.

   l. Investigate the results of goal setting for the chronically ill.

   m. Study the vocational adjustment of short-term patients who haven't been exposed to vocational rehabilitation services within the clinical setting or afterwards.

   n. Determine career opportunities for the physically handicapped in relation to travel limitations.

QUEENS COMMITTEE FOR VOCATIONAL REHABILITATION SERVICES

Report on Service Agencies

August 30, 1968

The population of the Borough of Queens is approximately two million people. The most conservative possible estimate of how many of these people need and could benefit from rehabilitation services would be 10% or 20,000 people. More likely, the true number needing rehabilitation services is more in the neighborhood of 50,000 to 100,000.

The Borough of Queens is one of the two largest boroughs of the City of New York. However, Queens is not only fourth in number of referrals to the Division of Vocational Rehabilitation, but a low fourth.

At the present time the rehabilitation facilities of Queens are serving between 300 and 400 people. Without further building, these facilities could serve 600 to 800 people. We, therefore, have the situation of the rehabilitation facilities of Queens being seriously underutilized.

In addition to those people receiving vocational rehabilitation services through the facilities, there is a much larger group which the Division of Vocational Rehabilitation serves by referring to business and trade schools, and colleges and universities. While we do not have the exact statistics on this group, there may be as many as 5,000 clients being served this way at the present time.

We must conclude that the system of referring people for and providing them with vocational rehabilitation services is in need of drastic overhaul. The professional personnel of Queens need to be educated to recognize people who require rehabilitation services so that they will refer these people for appropriate help. The Division of Vocational Rehabilitation needs to restructure and expand so that it may serve quickly and effectively a much greater number of people than they are now serving.

The above conclusions refer only to the quantitative aspects of serving the handicapped. We must also say that numbers go where there is success. It would seem to us that all of the rehabilitation facilities of Queens and the Division of Vocational Rehabilitation should thoroughly evaluate their methods of service, their staffing patterns, and the results that they are obtaining. We make this suggestion in the belief that if the rehabilitation facilities and the Division of Vocational Rehabilitation were restoring more people to remunerative employment at the highest level potential of the clients, the facilities and the Division of Vocational Rehabilitation would find themselves attracting greater numbers of people needing help.

APPENDIX D

STATEN ISLAND'S VOCATIONAL REHABILITATION NEEDS

1. Comprehensive Facilities: The site most often suggested is the Seaview Hospital and Home owned by New York City. St. Vincent's Medical Center of Richmond, in conjunction with the Staten Island Mental Health Society, hopes to establish a community mental health center. They already have the nucleus of a physical rehabilitation unit but do not have much more space on the site. If appropriate buildings were erected at Seaview, the St. Vincent's space could be readily used for other purposes.

2. "Regular" Sheltered Workshop: A sheltered workshop is desperately needed here. The Department of Social Services in December, 1967 had 300 Aid to the Disabled clients, only 99 of whom could travel off the Island. They also had 35 additional Home Relief clients who were disabled for employment and whom they thought qualified for sheltered workshop placement. There are no sheltered workshops on Staten Island.

3. Extended Care Sheltered Workshop: There is self-evident need for such a facility. There are none on Staten Island.

Efforts to establish rehabilitation services on Staten Island have been made since 1960 (and earlier) withour any paid staff. Survey and planning done in 1965 came to nothing for lack of funds. It has been impossible to develop even elementary vocational rehabilitation intake evaluation services here.

Only our least disabled get to DVR. Local people concerned with these problems were not interested in repeating it all in new committees. When something concrete is available, and the question is only location and type of service, they will be willing to be active again.

Items 1, 2 and 3 are important Staten Island needs. If Item 1 is too optimistic, Staten Island at least needs it own evaluation facility and St. Vincent's Medical Center would need expansion funds.

Mrs. John K. Bash,
Staten Island Borough Chairman

REPORT

of

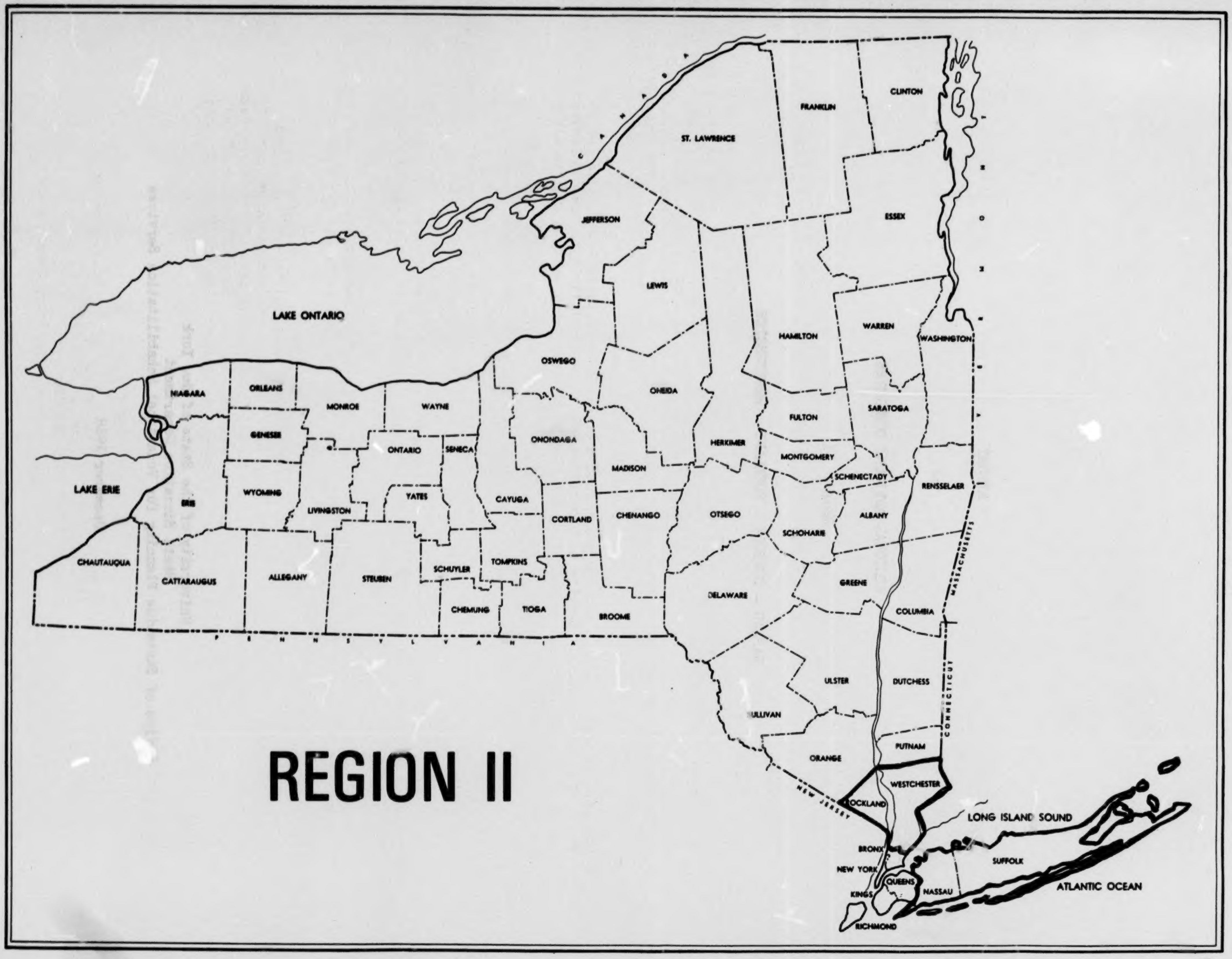
REGIONAL ADVISORY COMMITTEE

REGION II

NASSAU - SUFFOLK - ROCKLAND - WESTCHESTER

University of the State of New York
State Education Department
Office of Statewide Planning for Vocational Rehabilitation Services

December 1968


CANADA
VERMONT
LAKE ONTARIO
LAKE ERIE
PENNSYLVANIA
NEW JERSEY
CONNECTICUT
MASSACHUSETTS
LONG ISLAND SOUND
ATLANTIC OCEAN
ST. LAWRENCE
FRANKLIN
CLINTON
ESSEX
JEFFERSON
LEWIS
HAMILTON
WARREN
WASHINGTON
OSWEGO
ONEIDA
FULTON
SARATOGA
NIAGARA
ORLEANS
MONROE
WAYNE
GENESEE
ONTARIO
SENECA
ONONDAGA
HERKIMER
MONTGOMERY
SCHENECTADY
MADISON
RENSSELAER
ERIE
WYOMING
LIVINGSTON
YATES
CAYUGA
CORTLAND
CHENANGO
OTSEGO
ALBANY
SCHOHARIE
CHAUTAUQUA
CATTARAUGUS
ALLEGANY
STEUBEN
SCHUYLER
TOMPKINS
DELAWARE
GREENE
CHEMUNG
TIOGA
BROOME
COLUMBIA
ULSTER
DUTCHESS
SULLIVAN
PUTNAM
ORANGE
WESTCHESTER
ROCKLAND
BRONX
NEW YORK
SUFFOLK
QUEENS
NASSAU
KINGS
RICHMOND

REGION II

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
OFFICE FOR STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION SERVICES
225 PARK AVENUE SOUTH - ROOM 1301, NEW YORK, NEW YORK 10003

REGION II ADVISORY COMMITTEE
ESTHER MALLACH, CHAIRMAN
HELEN KAPLAN, VICE CHAIRMAN

ELIZABETH ANDERSON
REGIONAL PLANNING DIRECTOR

March 31, 1969

Mr. Sol Richman, Director
Office for Statewide Planning
  for Vocational Rehabilitation Services
162 Washington Avenue
Albany, New York 12210

Dear Sol:

It is with pride in the men and women who served on the Regional Advisory Committee, Region II, Statewide Planning for Vocational Rehabilitation Services that I submit herewith the attached report.

As you know, I was concerned from the start of our study about the awesome responsibility of the job and whether it was quixotic to expect a report of depth from a group of very involved men and women who would be giving volunteer time. I have found that it could be done, largely due to the commitment of the men and women invited by Commissioner James E. Allen to serve with me on the committee, to the always helpful ideas and enthusiasm of Mrs. Helen Kaplan, my Vice Chairman, and to the total dedication of Mrs. Elizabeth Anderson, our Regional Planning Director.

Our committee consisted of men and women with a high degree of sophistication in the field of rehabilitation. Despite an understandable tendency at first to discuss issues in terms of organizational orientation, invariably as the problem emerged and the need was recognized, the focus shifted to and stayed on the client.

Such a group of men and women will expect to be informed from time to time about the status of the study and its implementation; particularly so with the recommendations that call for changes which are more than procedural, which call for basic changes in philosophy. They recognize that change comes slowly, but they want the groundwork for change laid quickly. They expect to be called upon to help bring about change and will work for it. I feel confident that, if some extension of the present committee were needed for implementation of the plan, you would find that a large number of the committee members would be pleased to continue serving.

A valuable by-product of the study is the closer communication and understanding that now exists among colleagues in government and private agencies as a result of meeting and working together on the regional study.

In closing, I want to repeat my indebtedness to Mrs. Anderson and Miss Walker of your staff, who were untiring in their efforts and were determined to assure the success of the assignment, and to yourself for your help and guidance since that day about two years ago when I said "yes". My very deep appreciation and thanks go to every member of the committee and the consultants for their generous commitment of time and thought to this study.

With warm personal regards,

Sincerely,

Esther D. Mallach

Esther D. Mallach
Chairman
Region II Advisory Committee

TABLE OF CONTENTS

Regional Map 150

Regional Committee Members and Consultants 154

Foreword 158

Digest of Principal Recommendations 159

I. Introduction 163

II. Planning Organization and Method of Operation 167

III. Findings and Recommendations: Disability Reports 169

- Communications Impairments 169
- Correctional Rehabilitation 174
- The Disadvantaged - Social and Economic Disability 180
- Heart, Cancer, Stroke and Other Medical Impairments 186
- Mental Handicaps 188
- Mental Retardation 190

Facilities and Workshops 196

Administrative Considerations 200

- Interagency Coordination of Programs 208
- The Schools and Rehabilitation 211

Manpower, Labor and Industry 216

Transportation and Architectural Barriers 224

Legislative Changes 228

Bibliography 230

Appendix A - Description of Career Ladder Positions in Rehabilitation Services, State of California 234

Appendix B - Manpower Requirements in Selected Areas 240

REGION II

Esther D. Mallach Chairman	Helen Kaplan Vice-Chairman

EXECUTIVE COMMITTEE

Westchester County

Phyllis Shearer	Chairman
Chester Williams	Vice-Chairman

Rockland County

Goodwin D. Katzen	Chairman
Norman Rubinson	Vice-Chairman

Nassau County

Joseph S. Barbaro	Chairman
Harold Richterman	Vice-Chairman

Suffolk County

Frank S. Gibson	Chairman
Alan Fite	Vice-Chairman

Division of Vocational Rehabilitation

Milton Finkelman
William C. Spinelli

Commission for the Blind and Visually Handicapped

Jesse Stornelli
Seymour Greenwald

Regional Rehabilitation Services Coordinator

Lavinia Davidson

REGIONAL ADVISORY COMMITTEE

John J. Allen, Director
Division of Family and Child Social Services
Westchester Department of Social Services
White Plains

Anthony Arce, M.D., Director
After-Care Clinics
New York State Department of Mental Hygiene
New York City

Joseph S. Barbaro, Commissioner
Nassau County Department of Social Services
Mineola

Joseph R. Bernstein, Director
Rockland County Mental Health Association, Inc.
Monsey

William A. Brumfield, Jr., M.D., Commissioner*
Westchester County Department of Health
White Plains

Charles Buckman, M.D., Director
Kings Park State Hospital
Kings Park

Adrian Cabral, Executive Director
Health and Welfare Council of Nassau County
Garden City

Michael T. F. Carpendale, M.D., Director
New York State Rehabilitation Hospital
West Haverstraw

Lavinia M. Davidson, Community Coordinator
New York State Rehabilitation Hospital
West Haverstraw

Howard R. Dean, Counselor
Division of Vocational Rehabilitation
New York State Education Department
Garden City

Jack Dillman, Executive Director
Nassau-Suffolk Hospital Council, Inc.
Hicksville

William Donovan, M.D.
Regional Health Director
New York State Health Department
White Plains

John E. Dula, Executive Director
Westchester Council of Social Agencies
White Plains

Harry Dunbar, Consultant
Rockland County Community Action Council
West Nyack

Ronald J. Edeen, Director
Suffolk County Department of Correction
Yaphank

Fred Fant, Senior Probation Consultant
Division of Probation
New York State Department of Correction
New York City

Leona Farrington
New Rochelle Board of Education Advisory Committee
New Rochelle

Milton Finkelman, District Supervisor
Division of Vocational Rehabilitation
New York State Education Department
White Plains

Alan N. Fite, Executive Director
Suffolk Community Council, Inc.
Hauppauge

Alan Gartner, Executive Director*
Economic Opportunity Council of Suffolk, Inc.
Patchogue

Frank J. Gibson, Executive Secretary
Suffolk Tuberculosis and Health Association
Riverhead

Donald Gingras, Senior Parole Officer
Division of Parole
Executive Department
New York City

George D. Goldman, Director
Postdoctoral Psychotherapy Center
Adelphi University
Garden City

Jack J. Goldman, M.D., First Deputy Commissioner
Westchester County Department of Health
White Plains

Seymour Greenwald, Senior Counselor
Commission for the Blind and Visually Handicapped
New York State Department of Social Services
Jamaica

Emanuel Hacken, M.D., Assistant Director
Rockland State Hospital
Orangeburg

Reverend Martin J. Hall, Commission Member
Temporary State Commission to Study the Problems
of the Deaf
Seaford

William H. Heath, Executive Director
Suffolk County Organization for the Promotion
of Education
Oakdale

Donald B. Herd, Director
Long Island Health and Hospital
Planning Council, Inc.
Hicksville

Farrell Jones, Executive Director
Nassau County Committee on Human Rights
Mineola

Ferdinand Jones, President
Psychological Association of Westchester
Ossining

Helen Kaplan, Executive Director
Nassau County Chapter, Association
for the Help of Retarded Children
Brookville

Goodwin D. Katzen, Executive Director
Rockland County Center for the Physically
Handicapped, Inc.
New City

John L. Kearse, Executive Director
Economic Opportunity Council for
the Five Towns, Inc.
Inwood

Jane S. Kelley, Vice-Chairman
Westchester Citizens Committee of the National
Council on Crime and Delinquency
White Plains

Joseph Kinnaman, M.D., Commissioner
Nassau County Department of Health
Mineola

James E. Kirby, Commissioner
Suffolk County Department of Social Services
Bayshore

Edwin W. Kirk, Commissioner*
Rockland County Department of Social Services
New City

Hejmer R. K. Klint, Chairman
Rockland Branch, National Association
of Social Workers
Blauvelt

Lee E. Koppleman, Director of Planning*
Nassau-Suffolk Regional Planning Board
Hauppauge

Richard M. Lash, Executive Director
Suffolk Rehabilitation Center for the Physically
Handicapped, Inc.
Commack

Edward B. Leahy, M.D.
Assistant Clinical Professor of Orthopedic Surgery
Columbia University
South Nyack

George E. Leone, M.D., Health Commissioner
Suffolk County Department of Health
Riverhead

Edward S. Lorenze, M.D., Director
Burke Rehabilitation Center
White Plains

Esther D. Mallach, Executive Director
Mental Health Association of
Westchester County, Inc.
White Plains

Carmine Mangano, Director of Social Services
Grasslands Hospital (Westchester County)
Valhalla

Sidney Marks, Executive Director
United Cerebral Palsy Association of
Nassau County, Inc.
Roosevelt

Lucille Mayo
Assistant Director of Rehabilitation
Workmen's Compensation Board
New York City

John E. Miller, Superintendent
Great Neck Public Schools
Great Neck

Leo H. Miller, Member of the Board
Suffolk County Mental Health Association
Centerport

Edmund C. Neuhaus, Director
The Rehabilitation Institute
Mineola

Clarence A. Newallo, President
Hempstead Branch, National Association for
the Advancement of Colored People
Hempstead

Francis J. O'Neill, M.D., Director
Central Islip State Hospital
Central Islip

Saul Parker, Field Consultant
State Office of Economic Opportunity
New York City

Edward D. Pellegrino, M.D., Director
Health Science Center
State University of New York at Stony Brook
Stony Brook

Marilyn Pierce, Coordinator
School Social Work
New Rochelle Board of Education
New Rochelle

Peter Puglia, Secretary
Westchester County AFL-CIO Central Labor Body
Hastings-on-Hudson

Raymond C. Rieger, Director of Probation
Westchester County Department of Probation
White Plains

Grant Reynolds
Counselor at Law
White Plains

Harold Richterman
Coordinator of Rehabilitation Services
National Industries for the Blind
New York City

Ruth Rosenberg, Chairman
Rockland County Community Mental Health Board
Monsey

Norman W. Rubinson, Director
Rockland County Health Complex
New City

Walter J. Schoen, Jr., Dean
Rockland Community College
Suffern

Gertrude Seely, President*
Suffolk County Mental Health Association
Riverhead

Viola Shanahan, Executive Director
Association for Retarded Children, Inc.
Patchogue

Phyllis Shearer, Executive Director
Westchester Community Opportunity Program, Inc.
Hartsdale

William C. Spinelli, District Supervisor
Division of Vocational Rehabilitation
New York State Education Department
Garden City

Jesse Stornelli, Senior Rehabilitation Counselor
Commission for the Blind and Visually Handicapped
New York State Department of Social Services
White Plains

Lou V. Tempera, Commissioner
Suffolk County Department of Labor
Commack

W. E. Burghardt Turner, Chairman
Employment Committee, Suffolk County
Human Relations Commission
Patchogue

Boris Vanadzin, M.D., Commissioner of Health
Rockland County Department of Health
West Haverstraw

John Van Buren, Consultant
Nassau County Commission on Human Rights
Hempstead

Peter Van Putten, Jr.
Assistant to the Director of Personnel
Grumman Aircraft Engineering Corporation
Bethpage

Max Waldgeir, Director*
Area 5, State Department of Social Services
New York City

Chester Williams, Director
Westchester Lighthouse for the Blind
White Plains

Manuel Zane, M.D.
Montefiore Hospital
White Plains

Rita Zielenski, Executive Director
Skills Unlimited, Inc.
East Islip

CONSULTANTS

Dorothy Allensworth
White Plains

Nicholas Antoncic
Riverhead

Francis C. Bauer, M.D.
Huntington

Samuel Bea
White Plains

Gertrude K. Berman
Freeport

Joseph J. Blaney
White Plains

A. Thomas Castelli
West Nyack

Elaine Cohen
Scarsdale

John Connolly
New York City

John B. Diebler
Mineola

William Douglas
Garden City

Alan Edelman
New York City

Donald C. Farmer
Garden City

William Farrell, M.D.
White Plains

Katherine L. Friedmann, M.D.
Purchase

Marjorie Greene, M.D.
Hicksville

Lillian Grumann
Hempstead

Winona Halligan
Tuckahoe

Joseph Helper
Oceanside

Herbert Herman
Mineola

Milton Holtzman, M.D.
Oceanside

Leo C. Kaye
Roslyn

William Knott
New York City

Arthur E. Krueger
East Meadow

Edward J. Leber
Mineola

Lucy K. Lemmer
Hauppauge

Joseph Linda
New York City

Raymond Linderman
New City

Kate Loree
Rye

Elizabeth Lynch
Bedford Hills

Richard Match
Mineola

Eugene Moskowitz, M.D.
Valhalla

John A. Mulholland
New City

Joseph Murphy
White Plains

Nicholas Nardozzi
New York City

William J. O'Brien
Valhalla

Elizabeth L. Russell
Purchase

Elias B. Saltzman
New York City

Louise Simon
Pelham

Sister Bonaventura
Valhalla

Allen Stephenson
White Plains

Barbara Suarez
White Plains

Sioux Taylor
White Plains

Henry Viscardi, Jr.
Albertson

Marvin Wayne
New York City

Emil Weiss
White Plains

William Wyley
Lynbrook

*Resigned

FOREWORD

When key people representing the broad scope of across-the-board community functions and services were asked by James E. Allen, Jr., President of the University of the State of New York and Commissioner of Education, to serve on a Region II Rehabilitation Planning Committee, no one could, with any degree of accuracy predict whether or not, however sound, such an idea was workable.

No one could say with certainty how much or how little time would be required to get the job done. No one would venture to guess at the problems that might ensue, or the ingenious and determined ways devised to meet them.

New ideas, new ways of working with old problems, even those existing but not yet uncovered, have emerged with enormous hard work, great dedication, commitment and purpose, not to say enduring patience with the strengths and weaknesses of the human condition and its complexities.

Nor was love absent - love of home, community, humankind and the willingness to suffer, if only a little, to ensure more meaningful, more inclusive, fuller, wider, and more purposeful utilization of resources and services in rehabilitation for more people.

In Region II, new directions and new affirmations for better delivery systems in rehabilitation services have emerged and are viable. Permanent local structure has been agreed upon including coordinative functions.

A new federal structure and enabling legislation have already been provided to give new vistas and self-realization goals to the disabled and disadvantaged, including migrant workers.

What started with the community, must assuredly remain the responsibility of the community. Yet we know now, all of us, that the community itself must be stronger and more responsive to hear and heal those who are beyond their own efforts to help themselves and to whom we, who see the wrongs and try to right them, must give the required resources.

Mrs. Elizabeth H. Anderson
Regional Planning Director

DIGEST OF PRINCIPAL RECOMMENDATIONS

The findings and recommendations of the Region II Planning Advisory Committee are presented in the report which follows. Summarized here, not necessarily in order of priority, are recommendations of particular importance.

Administrative Considerations

A DEPARTMENT OF REHABILITATION OR HUMAN RESOURCES AGENCY SHOULD BE CREATED TO COORDINATE AND ADMINISTER ALL CURRENT AND FUTURE REHABILITATION PROGRAMS. A COORDINATED PLANNING PROGRAM SHOULD BE AN INTEGRAL PART OF THIS STRUCTURE.

CONSUMERS OF SERVICE, NOT ONLY THEIR SURROGATES, MUST BE APPOINTED TO POLICY MAKING BOARDS AND COMMITTEES IN EVERY SERVICE AREA TO INSURE THE DELIVERY OF VOCATIONAL REHABILITATION SERVICES.

STATE AND FEDERAL GRANTS AT ASSOCIATE, BACCALAUREATE AND GRADUATE LEVELS MUST BE INCREASED TO TRAIN REHABILITATION AND ANCILLARY PERSONNEL.

COMMUNITY VOLUNTEERS USED AGAIN AND AGAIN IN PLANNING AND OTHER SERVICE PROGRAMS RESPOND MORE FAVORABLY TO THE POSSIBILITY OF IMPLEMENTATION OF CAREFULLY DEFINED NEEDS THAN THE FRUSTRATION OF EXERCISES IN FUTILITY.

Legislative Changes

SUBSIDIES FOR TRANSPORTATION UP TO 90 PERCENT OF THE COST ARE NEEDED FOR THE DISABLED AND DISADVANTAGED. SUBSIDIES SHOULD BE FLEXIBLE AND RELATED TO THE COST OF LIVING INDEX IN THE AREA IN WHICH THE INDIVIDUAL LIVES.

A GUARANTEED INCOME PLAN OF NOT LESS THAN THE MINIMUM WAGE FOR DISABLED SINGLE INDIVIDUALS AND MINIMUM COST OF LIVING STANDARDS FOR MARRIED DISABLED AND FAMILY IS URGENTLY NEEDED. FOR EXAMPLE, IF THE MINIMUM COST OF LIVING STANDARD FOR FOUR IS $7,000 PER YEAR, THE DISABLED SHOULD BE PAID THE DIFFERENCE BETWEEN HIS PAY CHECK AND THE COST OF LIVING STANDARD.

A MINIMUM INCOME OF $3,000 PER YEAR SHOULD BE PAID TO THE PROFOUNDLY RETARDED UNDER THE PROVISIONS OF AID TO THE DISABLED OF THE SOCIAL SECURITY ACT.

THE AID TO THE TOTALLY DISABLED PROGRAMS SHOULD BE REMOVED FROM WELFARE OR SOCIAL SERVICE DEPARTMENTS, AND THE PROGRAM BENEFITS SHOULD BE PAID DIRECTLY TO RECIPIENTS BY THE SOCIAL SECURITY ADMINISTRATION.

MEDICAID SHOULD BE PROVIDED TO ALL MENTALLY RETARDED OVER AND ABOVE A GUARANTEED INCOME PROGRAM.

New Patterns of Service

REHABILITATION SERVICES SHOULD BE DECENTRALIZED AND OPERATED ON REGIONAL AND COUNTY LEVELS, WITH AUTHORITY GIVEN TO COUNTY COORDINATORS AND COUNTY REHABILITATION COUNCILS.

MULTI-SERVICE ONE-STOP AGENCIES ARE TO BE SET UP IN THE INNER CITIES WHERE INCIDENCE OF DISABILITY IS HIGH WITH REHABILITATION AGENCIES EFFECTIVELY INVOLVED IN OUTREACH AND ADVOCACY.

PARAPROFESSIONALS AND OTHER REHABILITATION AIDES SHOULD BE HIRED FROM THE NEIGHBORHOOD WHERE SERVICES ARE TO BE PROVIDED.

MOBILE REHABILITATION, HEALTH AND ANCILLARY SERVICES ARE TO BE PROVIDED IN AREAS UNABLE TO RECEIVE SERVICES FROM ANY OTHER SOURCE.

SINCE THEY ARE OFTEN FOUND IN OUTLYING AREAS, THE FACILITIES OF STATE MENTAL HOSPITALS AND STATE SCHOOLS SHOULD BE EXTENDED TO PROVIDE MEDICAL, VOCATIONAL EVALUATION AND PERSONAL ADJUSTMENT SERVICES FOR COMMUNITY RESIDENTS WHO OFTEN HAVE NO OTHER RESOURCE.

INTERPRETERS FOR THE DEAF, SIGN LANGUAGE-PROFICIENT PROFESSIONALS AND PARAPROFESSIONALS, SHOULD SERVE AS ITINERANT RESOURCE PERSONS FOR TRAINING, PLACEMENT AND OTHER SERVICES.

SOCIAL-RECREATIONAL NEEDS OF THE DISABLED AND DISADVANTAGED SHOULD BE PROVIDED FOR IN EVALUATING EXISTING RESOURCES AND IMPLEMENTING NEEDED SERVICES.

IN MENTAL HEALTH, TOOLS, TECHNIQUES AND PROCEDURES MUST BE DEVELOPED TO REACH THE VAST NUMBERS OF THE "NON-PATIENT" GROUP WHO ARE NOT BEING SERVED AT THIS TIME.

Handicapped Children

A SERVICE CONTINUUM BEGINNING BEFORE BIRTH (A CASE IN POINT: RUBELLA INFECTION OF THE FOETUS CAUSING DEAFNESS) AND EXTENDING THROUGHOUT INFANCY, FORMATIVE YEARS, PUBERTY AND ADOLESCENCE IS A SINE QUA NON TO PREVENT IRREVERSIBLE HANDICAPS AS WELL AS TO ELIMINATE OR REDUCE DISABILITIES.

THE DISABLED MUST BE EDUCATED TO BE SOCIALLY USEFUL PERSONS IN AN ENVIRONMENT OF INCLUSION AND ACCEPTANCE, RATHER THAN IN ISOLATION. FOR EXAMPLE, PRE-SCHOOL PROGRAMS FOR CHILDREN SHOULD INCLUDE DISABLED CHILDREN.

SERVICES PROVIDED FOR PARENTS OF HANDICAPPED CHILDREN SHOULD INCLUDE EDUCATION IN COMMUNICATION METHODS, SOCIAL ADAPTATION AND ACCEPTANCE TECHNIQUES.

SCHOOL SERVICES SHOULD BE EXTENDED TO ADAPT ACADEMIC AND VOCATIONAL CURRICULA TO PREPARE HANDICAPPED CHILDREN FOR REALISTIC GOALS IN THE WORLD OF WORK. BOARDS OF COOPERATIVE EDUCATION SERVICES AND THE STATE REHABILITATION AGENCIES SHOULD SHARE A MAJOR COORDINATIVE ROLE IN THIS ADAPTATION.

The Disadvantaged

SUPPORTIVE SERVICES TO MAINTAIN PERMANENT EMPLOYMENT SHOULD BE PROVIDED TO THE HARD CORE UNEMPLOYED INCLUDING COUNSELOR CONTACT WITH THE EMPLOYER TO REINFORCE THIS OBJECTIVE.

SENSITIVITY TRAINING SHOULD BE PROVIDED TO ALL PERSONNEL WORKING WITH THE DISADVANTAGED TO EFFECTUATE COMMUNICATION, EMPATHY AND DELIVERY OF SERVICES.

THROUGH "WHEELS FOR THE HANDICAPPED" THE DISADVANTAGED CAN BE TRAINED TO PROVIDE TRANSPORTATION SERVICES FOR THE DISABLED. BY-PRODUCTS WILL INCLUDE AUTO MECHANICS AND BUILDING MAINTENANCE TRAINING, SECRETARIAL TRAINING, DISPATCHER TRAINING, PURCHASE AND SUPPLY CLERK TRAINING AND DRIVER TRAINING.

AREA VOCATIONAL CENTERS SHOULD BE USED DURING OFF-SCHOOL HOURS FOR REHABILITATION WORK ORIENTATION AND TRAINING.

WHEN NOT TRANSPORTING STUDENTS, SCHOOL BUSES COULD BE USED TO TRANSPORT THE DISABLED AND DISADVANTAGED TO AND FROM WORK AND TRAINING AREAS WHICH MAY BE REMOTE FROM THEIR HOMES.

BECAUSE THE NEED FOR MORE PROFESSIONALS WILL NOT BE MET BY EXISTING TRAINING RESOURCES, JOB ANALYSIS METHODS SHOULD BE USED TO ASCERTAIN REAL RATHER THAN STATUS JOB REQUIREMENTS AND PARAPROFESSIONALS OR AIDES TRAINED TO PERFORM SOME OF THESE SKILLS.

AN ADEQUATELY FINANCED COLLEGE CAREERS PILOT PROGRAM FOR FOUR TO FIVE YEARS SHOULD BE ESTABLISHED TO EDUCATE POORLY PREPARED DISADVANTAGED YOUTH AND INCLUDE CONTINUING SUPPORTIVE ADMINISTRATIVE AND COUNSELING SERVICES ESSENTIAL TO MEET THE NEEDS OF THE DISADVANTAGED YOUTH.

Correctional Rehabilitation

PREVENTIVE CORRECTIONAL MEASURES SHOULD INCLUDE WORK RELEASE PROGRAMS, RELEASE ON OWN RECOGNIZANCE, REHABILITATION AND TRAINING IN AND OUT OF INSTITUTIONS, THE TREATMENT OF ALCOHOLISM AS A DISEASE RATHER THAN AN OFFENSE, AND UTILIZATION OF HALFWAY HOUSES FOR ADJUSTMENT OPPORTUNITIES.

A CLEAR DEFINITION OF SOCIAL DISABILITY AS WELL AS CLEAR REQUIREMENTS FOR ELIGIBILITY ARE URGENT PREREQUISITES TO PROVIDE SERVICES TO CORRECTIONS CLIENTS.

THE STATE LIQUOR AUTHORITY AND THE DEPARTMENT OF MOTOR VEHICLES SHOULD REVISE THEIR BARRIERS TO THE EMPLOYMENT OF CORRECTIONS CLIENTS AND THUS FACILITATE THEIR HIRING.

Employment of the Disabled

COUNSELORS SHOULD HAVE ACCESS TO THE NEW YORK STATE EMPLOYMENT SERVICE JOB LISTINGS AND WORK IN CLOSER COOPERATION WITH SELECTIVE PLACEMENT COUNSELORS.

PLACEMENT OF THE DISABLED IN STATE, COUNTY AND LOCAL CIVIL SERVICE JOBS CAN BE FACILITATED BY CLOSER COOPERATION BETWEEN REHABILITATION AGENCIES AND CIVIL SERVICE OFFICIALS.

LABOR GROUPS AND INDUSTRIAL FIRMS AND ORGANIZATIONS SHOULD BE ENCOURAGED TO HIRE THE DISABLED AND DISADVANTAGED AND SHOULD BE PROVIDED WITH ENABLING INFORMATION, STAFF ASSISTANCE AND FUNDING WHERE FEASIBLE.

NEW TECHNOLOGICAL DEVELOPMENTS AND COMPUTERIZATION CAN BE ADAPTED TO IMPROVE AND EXTEND TRAINING AND PLACEMENT OF THE DISABLED WITH MORE RELEVANCY TO INDUSTRIAL MANPOWER NEEDS.

Facilities

WORKSHOPS AND FACILITIES SHOULD RE-EVALUATE PROGRAMS, EQUIPMENT AND MACHINERY TO MORE EFFECTIVELY MEET THE NEEDS OF THE CLIENTS WHO MUST BE PREPARED FOR INDUSTRIAL CHANGES.

FEDERAL FORMULAS FOR NEW CONSTRUCTION OF VOCATIONAL TRAINING CENTERS AND OCCUPATIONAL DAY CENTERS SHOULD BE CHANGED TO PROVIDE AT LEAST 60 PERCENT OF THE COSTS. THE VOLUNTARY AGENCY SHOULD BE ABLE TO GET LOW INTEREST RATE MORTGAGE FUNDS FROM THE STATE THROUGH THE HOUSING FINANCE CORPORATION OR THE MENTAL HYGIENE FACILITIES IMPROVEMENT FUND.

TO AVOID IMPOSING STRUCTURES AND SERVICES UPON A COMMUNITY WHICH MIGHT BEAR NO RELATION TO ACTUAL NEEDS IN TERMS OF SERVICES AND THEIR GEOGRAPHIC LOCATION, THE COMMUNITIES, INCLUDING CONSUMERS OF SERVICE, SHOULD BE INVOLVED IN DECISION MAKING IN PLANNING FACILITIES AND WORKSHOPS.

Information and Education

COMMUNITY INFORMATION AND EDUCATION CENTERS AND PROGRAMS SHOULD BE DEVELOPED TO REACH VARIOUS PUBLICS INCLUDING, AMONG OTHERS, REHABILITATION CONSUMERS, PROSPECTIVE CLIENTS, PARAPROFESSIONALS AND PROFESSIONALS, AND TO ENCOURAGE MORE RECRUITS TO ENTER REHABILITATION AND ANCILLARY SERVICES.

SYSTEMS OF COMMUNICATIONS BETWEEN PROFESSIONALS TO ACQUAINT EACH OTHER WITH THEIR LANGUAGE, FRAMES OF REFERENCE, APPROACH, SERVICE PROGRAMS, GOALS AND FINANCING ARE A REQUISITE FOR SERVICE DELIVERY.

BETTER INFORMATION TO PHYSICIANS, HEALTH, HOSPITAL, VOLUNTARY AGENCY PERSONNEL AND SCHOOL PERSONNEL TO PROMOTE REFERRAL OF DISABLED INDIVIDUALS TO APPROPRIATE AND AVAILABLE REHABILITATION SERVICES MUST BE PROVIDED.

DATA COLLECTION, STORAGE AND RETRIEVAL SYSTEMS SHOULD BE SET UP TO FACILITATE DELIVERY OF SERVICES. THE SOCIAL SECURITY NUMBER, WITH PROPER SAFEGUARDS TO PREVENT ABUSE, CAN BE USED FOR IDENTIFICATION.

I. INTRODUCTION

This study emanates from an outstanding law passed by the 89th Congress of the United States in November 1965, Amendments to the Vocational Rehabilitation Act, Public Law 89-333. This law recognizes the inadequacies of existing legislation and the application of these laws at state and local levels with regard to: 1) delivery of services; 2) apparent gaps in service; 3) non-delivery of rehabilitation services to large segments of eligible citizens.

Why Are There Service Gaps?

Gaps in service delivery are due to many reasons, among them:

- lack of application of uniform standards for service;
- lack of patients referral by doctors and related medical personnel, by hospitals and other medical services aware of existing rehabilitation services;
- failure of schools and learning institutions to refer students for rehabilitation;
- failure of correctional institutions to refer eligible persons for rehabilitation services;
- failure of many other public, private, and voluntary agencies to refer persons for rehabilitation;
- lack of information to the community at large and the public, notably the socially disadvantaged, of available rehabilitation services, functions or agency locations. This last factor is probably the most important single factor as well as failure to develop and train critically needed professional and paraprofessional staff to provide rehabilitation services.

Affluence Masks Poverty and Disability

In New York State, Comprehensive Statewide Planning, which is one area of concern in this wise law, was implemented in 1967. Region II, one of the four planning regions designated in New York State, includes Nassau, Suffolk, Westchester and Rockland Counties, with a total population of 3,500,000.* This is the second largest planning region in the state and contains areas with the highest education and per capita income levels in the nation. Despite this there are disparate pockets of poverty in affluent Westchester and Nassau as well as in less affluent Suffolk and Rockland. This metropolitan area reports 99,683 persons receiving welfare as of June 1, 1968, or 3.5 percent of the population. Suffolk County has the greatest number of migrant workers and the lowest per capita income of the four counties. In Westchester, the cities of Mount Vernon and Yonkers have nearly 7,000 families living in abject poverty with an income under $3,000 per year. The rest of the county, including Tarrytown and Larchmont, account for almost 7,500 families in abject poverty. More than 50 percent of all black families in Westchester are deprived. Suffolk indicates 25,000 to 30,000 families living in poverty, including one out of four black families and one out of ten white families.

In these counties, the highest priority for rehabilitation services is allocated to the poor or socially disabled, validating the widely-held impression that physical and emotional handicaps are more prevalent among the catastrophically poor. There is a lack, however, in the delivery of community services to this group despite chilling popular beliefs that "hand-outs" are prevalent. In Westchester, for example, where ten percent of the population lives in abject poverty, only two percent were on the public welfare rolls in May, 1968. In Suffolk, where 25,000 to 30,000 families live in poverty, only one percent of the total population were on the welfare rolls as of June 1, 1968. It is apparent then that approximately nine percent or more of the catastrophically poor eke out a miserable living without any kind of assistance from public welfare, yet they are probably eligible for welfare supplements. If these poor have been identified and counted, and it appears they have, then ways will have to be found to establish contact with them at the local level, to elicit health and other presumed problems and to make appropriate referrals to rehabilitation and other services.

California, apparently unique among the 50 states, is the only state with implemented programs of advocacy and outreach utilizing indigenous paraprofessionals who do an effective job of serving the disadvantaged who are disabled. New York State, with some of the poorest sections of the country in the inner cities of Bedford-Stuyvesant, Central Harlem and the South Bronx, can no longer sit idly by with a "business as usual" approach to rehabilitation without sustaining serious dislocation generated by frustration and hopelessness in the midst of underutilized services and resources.

*See Tables on p.153 for demographic projections and disability estimates in Region II.

DEMOGRAPHIC PROJECTIONS - REGION II

	Nassau	Suffolk	Westchester	Rockland
1965	1,386,980	910,311	856,427	182,182
1970	1,444,148	1,155,100	946,854	231,292
1975	1,510,834	1,379,534	1,043,800	265,785

1965 Totals	1970 Totals - Projected	1975 Totals - Projected
1,386,980	1,444,148	1,510,834
910,311	1,155,100	1,379,534
856,427	946,854	1,043,800
182,182	231,292	265,785
3,335,900	2,777,394	4,199,953

SOURCE: Demographic Projections for New York State Counties to 2020 A.D., New York State Office of Planning Coordination

PROJECTED GENERAL POPULATION AND NUMBER OF INDIVIDUALS LIMITED IN ABILITY TO PERFORM MAJOR FUNCTION IN 1975 BY AGE AND COLOR

All Ages	Projected General Population*			Projected Number of Individuals Limited In Ability To Perform Major Function		
	White	Non-White	Total	White	Non-White	Total
All Ages	3931577	267879	4199456	82365	8665	91030
0-16	1224573	72061	1296634	2449	216	2665
17-44	1438148	117717	1555865	7190	1413	8603
45-64	940449	62846	1003295	24451	3206	27657
65	328407	15255	343662	48275	3830	52105

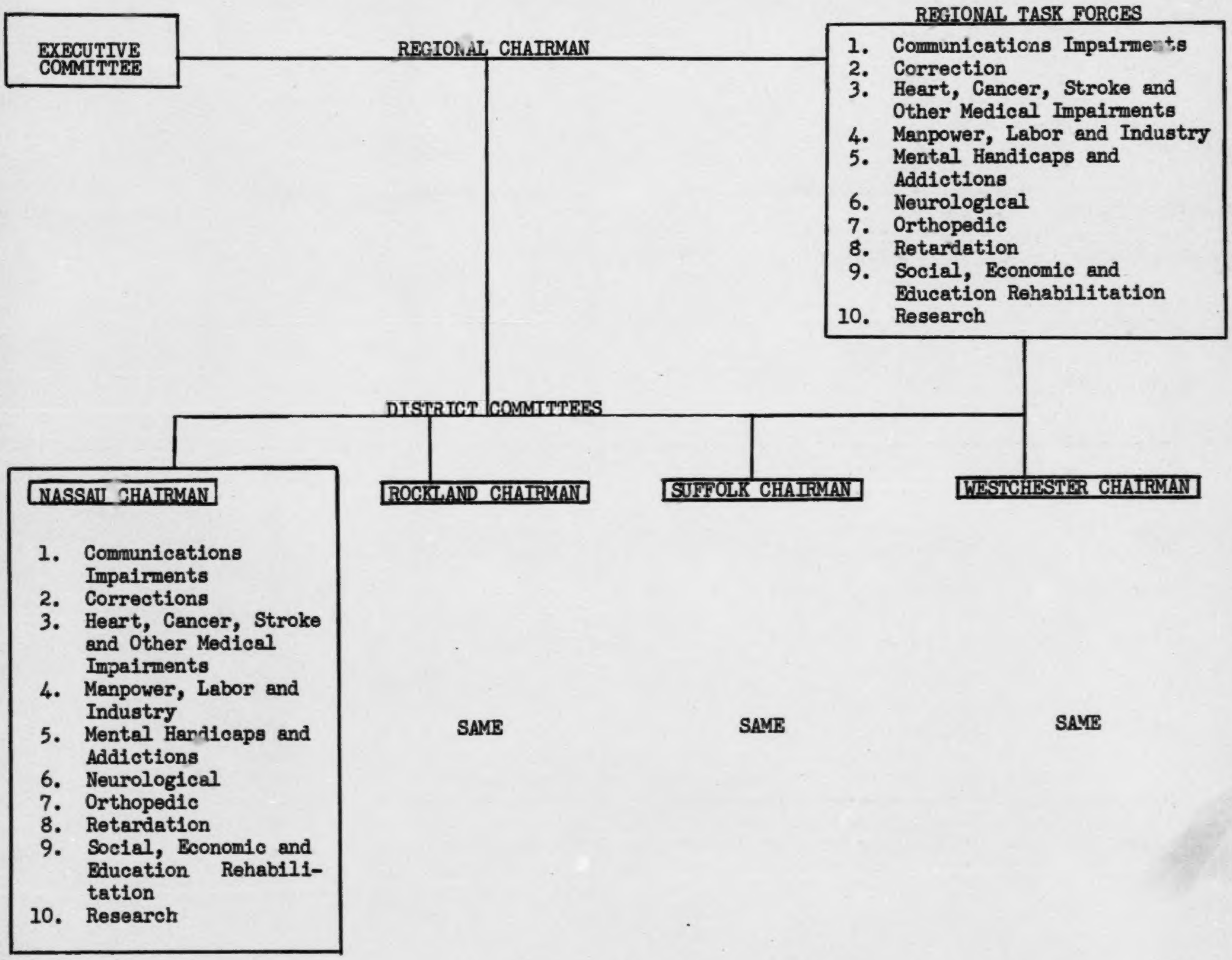
*Based on Office of Planning Coordination Projections

Approach To The Task

In Region II, advisory committees were asked in the first phase to: look at existing local rehabilitation agencies and services, evaluate the services provided in terms of what kinds existed, who was getting service, and who was not getting service, and evaluate the effectiveness of the services provided. Each advisory committee did this on a county or district basis. The second phase was: "What else is needed?" This refers to services needed but not provided, and populations needing services but not receiving them. The third phase, "What is required to meet these needs?" deals with the delivery of services.

There is reason to hope that a permanent advisory-planning structure will emerge in Region II which will facilitate the delivery of services to more of those persons who need them. Techniques and processes for service delivery systems should be developed on a county as well as a regional basis. Restructuring the Region geographically may be needed to complement existing health or other planning regions for more effective service delivery.

REGION II ADVISORY COMMITTEE ORGANIZATIONAL CHART



REGIONAL TASK FORCES

1. Communications Impairments
2. Correction
3. Heart, Cancer, Stroke and Other Medical Impairments
4. Manpower, Labor and Industry
5. Mental Handicaps and Addictions
6. Neurological
7. Orthopedic
8. Retardation
9. Social, Economic and Education Rehabilitation
10. Research

NASSAU CHAIRMAN

1. Communications Impairments
2. Corrections
3. Heart, Cancer, Stroke and Other Medical Impairments
4. Manpower, Labor and Industry
5. Mental Handicaps and Addictions
6. Neurological
7. Orthopedic
8. Retardation
9. Social, Economic and Education Rehabilitation
10. Research

II. PLANNING ORGANIZATION AND METHOD OF OPERATION

Geographical and Functional Structure

For the purposes of planning, Region II was divided into four districts which are coterminous with each of the four counties in this region: Nassau, Suffolk, Westchester and Rockland.

The Executive Committee served as the coordinating body, consisting of the Region II chairman and vice chairman, the Regional Task Force chairman, the District chairmen and vice-chairmen, and representatives from New York State departments or agencies (Workmen's Compensation, Division of Vocational Rehabilitation, Office of Economic Opportunity, Parole, Correction, Social Services, Commission for the Blind, Commission for the Deaf).*

Each district prepared a preliminary and final report within the framework of three phases: I. What exists now? II. What else is needed? III. What is required to meet these needs?

Each district also had ten study committees in the following areas: Communications Impairments; Corrections; Heart, Cancer, Stroke and Other Medical Impairments; Manpower, Labor and Industry; Mental Handicaps and Addictions; Mental Retardation; Neurological; Orthopedic; Social, Economic and Educational Rehabilitation; Research. (The Research Committee was charged with drawing up survey sheets, analyzing survey data, reporting to the district and region.) The reports of the ten committees were summarized through a regional task force, represented by the district chairmen responsible for the particular area of study.

The Region II chairman worked directly with Westchester and Rockland District, chairmen and committees, and the Region II vice-chairman with the Nassau and Suffolk Districts chairmen and committees. Meetings were usually held at least once monthly, or on demand when advisable.

Study Guidelines

A. Within the framework of the foci or areas of study, participants were given the following guidelines:

1. Summarize findings in foci area.
2. Describe characteristics of geographical unit, e.g., population, economy and income, industry, housing, legislation, local government and autonomy, schools and training facilities, other service functions.
3. State purpose and goals of group for each disability area.
4. Describe techniques and tools designed for this phase of planning include objective statement of difficulties and problems. Attach questionnaire as appendix; add other appendices as necessary or desirable.
5. Describe agencies studied--their services and purposes, goals, groups served, problems, limitation; analyze data received, projected or extrapolated.
6. Describe services adequately utilized, over or underutilized, gaps in services, and impediments to providing service.
7. Describe populations served and not served.
8. Describe adequacy or inadequacy of existing services.
9. Describe transportation problems and existing services.
10. Describe recreation problems and existing services.
11. Describe interactions of committee in terms of accepting assignment, positive or negative action which affected group goals. Indicate projections of committee interrelationships that will affect group goals.
12. Conclusions. Opinions should be documented by data and bibliography. Recommendations should be part of Phase II, "What else is needed?"

---

*See Organization Chart p. 165

B. The general frame of reference participants were given had three phases:

What exists now?
The nature, extent, implications of current services and operation.
Who is receiving benefits and services?

What else is needed?
Identification of population not now being served but needing services.
Identification of services needed but not provided.
Recommendations to provide needed services.

What is required to meet these needs?
Plan comprehensively for 1975 in Nassau, Suffolk, Rockland and Westchester, utilizing every possible resource for implementation, considering a permanent district structure, a change in state structure, and the development of delivery systems.

Selection of Task Force Members

District chairmen were designated by the regional chairman. They, in turn, selected task force chairmen.

The four districts were advised by the regional planning director to broaden and extend participation on committees and sub-committees to include as many community groups as possible, including consumers of services.

Some districts acted as a committee of the whole to do its work; others had individual committees. Some grouped several committees.

Survey Used for Information

The regional planning director sent suggestions for relevant survey material to district committees. Many committees decided to design their own survey instrument according to need. In the Westchester district, one survey instrument used was designed by the Albany Office for Statewide Planning, with the Westchester Manpower, Labor and Industry Committee and the Correction Task Force designing their own survey instruments.

The returned questionnaires, although supplying desired information, presented formidable data analysis problems. An I.B.M. consultant, called in by the regional chairman, indicated that data survey processes were necessarily complex and expensive and should be designed in terms of what the survey was expected to do. Nevertheless, reporting was done on the basis of survey material received. Acknowledging the survey materials' inprecision, the resulting data is, in fact, more than we had before and serves as a basic and necessary information source.

Participation

Busy, over-committed executives, consumers of services, local, county and state officials and their staffs, volunteers, and representatives of important community services worked long, hard hours without complaint and with superb skill and dedication to complete work never before done in the area of rehabilitation. This unprecedented utilization of county skills across the board without any previous tracks has led to new insights and concepts in rehabilitation. In addition, more than 125 county representatives are now committed to local permanent rehabilitation planning groups with a permanent county rehabilitation coordinator in the office of the county executive.

Although delegate representation was encouraged when the committee member could not participate, this alternative was seldom used. A few members resigned because of time commitments.

More than half of the regional task force chairmen submitted reports by target dates. Although a preliminary report of the Governor's Special Committee on Criminal Offenders recommended that Corrections Rehabilitation be separate and apart from comprehensive rehabilitation, members of the Region II Corrections Task Force continued their affiliation and study.

The state reimbursed expenses for mileage, meals and tolls for committee members. In addition to the sacrifice of time, some Region II members have not asked for reimbursement of funds and have apparently chosen to make an additional contribution in this way.

The regional planning director and Office for Statewide Planning provided ample and substantive materials in many areas of concern for committee study and reference.

It should be noted that in Region II a survey of rehabilitation facilities and workshops was undertaken by other planning committees in the counties. This material as well as other public and private agency information which has been reported has been freely used in the Region II report.

III. FINDINGS AND RECOMMENDATIONS: DISABILITY REPORTS

COMMUNICATIONS IMPAIRMENTS

Communications disabilities are a major national health problem. Included in this group are the following:

- those who are blind or who have handicapping visual conditions,
- the totally deaf, the deafened, the hard of hearing,
- disorders of speech affecting articulation: those with cleft palate, facial malformation, other birth defects and organic disorders including cerebral palsy which may predispose a speech defect.

In Region II the rehabilitation of these groups is largely the responsibility of the Commission for the Blind and Visually Handicapped and the Division of Vocational Rehabilitation. Private agencies with major rehabilitation emphasis are the Industrial Home for the Blind, the Westchester Lighthouse, and the United Cerebral Palsy Association of Nassau County.

Sensory disability of sight and/or hearing requires the services of professionals and others who have the necessary unique skills to provide restoration of functioning, and adaptation or accommodation to the total environment. Among other services, surgery, optical aids, mobility training, hearing aids, auditory training, speech therapy, sign language, interpreters for the deaf, and prostheses can all be used in effectuating adjustment of the communications impaired to the immediate environment and to society.

It might be expected that the needs of persons with communications impairments would be similar to the needs of most of humanity, yet eloquent statements of their needs implies indifference, rejection, or both, by the society:*

1. To be understood.

   This includes communication, both the sending and receiving of thoughts. It also includes understanding the impact of the disability upon the physical, social, vocational, emotional and spiritual growth and functioning of the person affected. This understanding assumes the insight and responsiveness of the humanitarian with his inborn aspirations for mankind as distinct from the disinterested objectivity of the scientist.

2. To be treated as individuals.

   There is widespread vocational, psychological and educational stereotyping of people who have communications impairments. Teachers, counselors, audiologists, psychologists and placement officers frequently use a label as a guide, ignoring the psychology of individual differences.

3. To be held to the same standards of performance as their peers.

   In education in particular, the impaired are permitted to perform at levels less than their potential. This may sometimes be true in social intercourse also. This is a deplorable aspect of the paternalism currently prevalent which may stem from over-simplification of educational and rehabilitation needs.

---

*Boyce Williams, Consultant for the Deaf, U.S. Department of Health, Education and Welfare, "Basic Needs of Deaf People," The Pelican, December 1964. Reprint.

4. To be served by real professionals in all areas.

   Their teachers, vocational rehabilitation counselors, psychologists, social workers, ministers, audiologists, medical workers, must all be top-notch professional people, not visionary "do gooders." The latter do not usually understand the basic importance that deaf or blind people be treated as individuals and that they be held to regular standards of performance.

5. To be allowed time to learn.

   The story of deaf people, for example, is replete with examples of too little time being taken to give them the tools for living up to their potentials. It should be understood that the majority of graduates from schools for the deaf require training beyond that which they acquire during their years in school. Diversified training opportunities should be seriously considered for each person rather than the limited patterns prevailing in the fixed school situation. Do professional workers serving deaf people allow or have the much greater time necessary to do more effective work?

6. To be held equal, to be integrated.

   The prevailing pattern of paternalism extant toward the communications impaired thwarts integration into the larger community. Moreover it is a heavy damper on social and professional growth, because it avoids recognition and use of opportunities to involve impaired people in social and work situations appropriate to their overall competencies.

7. To achieve social maturity.

   The immaturity of the society of deaf people, its naivete, its unsophistication, have been demonstrated in research and training efforts and in other ways. The society of the deaf moves pretty much along without any real help from hearing colleagues. Hence, it feeds mainly on itself and fails to keep pace with society in general. This comment may be true for the isolated blind, but it is not true for the general blind population.

8. To attain opportunities commensurate with capacities.

   In vocational rehabilitation we are aware of the pressing needs to expand sharply and elevate job opportunities. Too many high-grade communications impaired people with college degrees are running automatic machines, thus depriving society of their creative potential. Limitations in educational opportunities are a fundamental cause.

9. To be accepted as full-fledged partners.

   The special knowledge and skills of qualified deaf or blind people are seldom used or solicited by workers who serve them. This retards development, as special problems often miss the proper target. Involvement of the proved creativeness, drive and motivation of these people results in practical solutions to needs.

10. To be given equal service opportunities.

    The dearth of needed resources such as halfway houses, sheltered workshops, personal adjustment centers, and other rehabilitation centers to meet the urgent needs of the more severely handicapped illustrates the serious inequalities prevailing. The persistent professional personnel shortages complicate the solution.

11. To replace attitudes of complacency and apathy.

    For many reasons those who have communications impairments and their friends share an apologetic attitude regarding their relative competencies. The resultant low-level aims keeps the disability group functioning at a needless disadvantage which compounds itself as time moves on.

Poor self-image, or perhaps defeat and resignation resulting from affliction by the overwhelming obstacles society erects to thwart participation, are characteristic of many inpaired or disabled persons. Rehabilitation is the accepted program and most effective program to develop or restore a more positive self-image through self-actualization.

The problems of those disabled who have communications impairments -- those who are blind, deaf, or have speech disorders -- were studied by a Region II Communications Impairment Task Force. The Task Force looked at the future as well as the present.

A look at the future considered what technological advances might be available for disability groups. For the blind, there will probably be increased use of audio tapes both for transmitting messages and speed reading. Machines may scan regular or special print and transmit the results in sound for the blind or vibrations for the deaf-blind. And greater advancement in the use of low vision aids and surgical operations could result in better vision for many.

In the area of present needs, the Task Force discussed preventive health measures which should be required in vision, hearing and speech areas to reduce the number of those who are needlessly disabled, the need for professional standards for prescribing eye glasses and hearing aids, and the need to bring service systems nearer the consumer who should be a part of policy making agencies. The group also considered the need for professionals and paraprofessionals who work with the communications impaired to share experiences and techniques which will advance existing therapies and develop new approaches.

The Task Force also discussed the substantial evidence that persons who do not have communications impairments are still unable to communicate meaningfully and effectively with each other, as individuals and as groups. Developing communication skills and solving the problems relating to the inability of non-impaired individuals to give, receive and retain information is urgently needed in our industrialized society. But, for those persons who have communications inpairments, there is an even greater and more critical need to develop communication skills. Non-impaired persons, if they are aware of their own occasional inability to communicate, have a perspective necessary to understanding the many obstacles to effective communication that exist for the person who is blind, deaf, or has speech disorders.

The Communications Impairment Task Force findings, recommendations and rationale are comprehensive for Region II and indicate needed new approaches and legislative changes. The recommendations and rationale follow.

The Blind

UNTIL SUCH TIME THAT THE TWO STATE VOCATIONAL REHABILITATION AGENCIES ARE COMBINED OR MERGED, A STUDY SHOULD BE MADE JOINTLY SPONSORED BY THE DIVISION OF VOCATIONAL REHABILITATION AND THE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED TO DETERMINE THE FEASIBILITY OF THE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED OFFERING SERVICES TO BOTH THE BLIND AND VISUALLY IMPAIRED (NOT BLIND BY DEFINITION) PERSONS. PRIORITY: ESSENTIAL

THERE IS NEED FOR A COMMITTEE TO STUDY THE REGISTRY FOR THE BLIND IN NEW YORK STATE -- TO CONSIDER THE PROBLEMS OF MAINTAINING A REGISTRY AND ITS DEVELOPMENT, APPLICATION AND VALIDITY IN THE CONTEXT OF DEVELOPING A REGISTRY FOR ALL THE HANDICAPPED. PRIORITY: URGENT

> This study should be on a regional basis to assist the Commission for the Blind and Visually Handicapped and private agencies in future planning and programming of services. The confidentiality of information and the rights of the individual would be respected.

WE RECOMMEND THAT EXISTING PRIVATE AGENCIES FOR THE BLIND EXPAND THEIR PROGRAMS TO PROVIDE COMPREHENSIVE REHABILITATION SERVICES TO OTHER DISABILITY GROUPS WHERE THERE ARE NOT A SUFFICIENT NUMBER OF BLIND CLIENTS AVAILABLE FOR SERVICES, PROVIDED THAT IN ANY COUNTY THE BLIND WOULD RECEIVE FIRST PRIORITY, AND, IN ADDITION, NO BLIND WOULD BE DENIED SERVICE BECAUSE OF THE NEEDS OF ANY OTHER DISABILITY GROUP.
PRIORITY: ESSENTIAL

> The State Rehabilitation Agency should assume responsibility for achieving these objectives.

GENERIC COMPREHENSIVE FACILITIES SHOULD EXPAND AND DEVELOP THEIR CAPABILITY TO SERVE BLIND PERSONS WHERE THERE ARE NO AGENCIES WHICH PROVIDE SPECIALIZED SERVICES FOR THE BLIND. THE VARIOUS DISCIPLINES IN THE GENERIC AGENCY SHOULD BE TRAINED IN ALL ASPECTS OF BLINDNESS AND NO GENERIC AGENCY SHOULD SERVE THE BLIND UNTIL THE PROFESSIONAL STAFF INVOLVED HAS RECEIVED APPROPRIATE TRAINING. PRIORITY: URGENT

The State Rehabilitation Agency should assume implementation responsibility.

WE RECOMMEND THE ESTABLISHMENT OF A COMPREHENSIVE REHABILITATION CENTER TO SERVE THE BLIND IN NASSAU OR SUFFOLK COUNTY, AND LOCATED IN EITHER OF THOSE COUNTIES IN A PLACE MOST CONVENIENT TO BOTH. PRIORITY: DESIRABLE

At this time the number of identified blind persons in either service in each of the counties would not be sufficient to warrant the establishment of a center in both but would meet an important existing need. It is further suggested that in the interim, during which the blind population is being discovered for service, the center could be used for other disabled, with the priority given to blind persons.

WE RECOMMEND THAT WHEREVER POSSIBLE, SERVICES IN BLIND AGENCIES BE PURCHASED ON A PACKAGE BASIS WHICH WOULD INCLUDE THE MAJOR TRAINING SERVICES SUPPLEMENTED AS NEEDED BY SUCH SERVICES AS CASE WORK, PSYCHOLOGICAL SERVICES AND REMEDIAL SERVICE AT A FEE TO COVER ACTUAL COSTS OF SUCH A GROUP OF SERVICES. PRIORITY: DESIRABLE

Reimbursement on a per case basis, as is done at the present time, is costly to administer and does not allow for flexibility of adding additional services as may be required in the day to day service program. At present each additional service requires specific authorization, a procedure which is clerically costly and time-consuming and not geared to meet the immediate situation of the client. It is also dependent upon approval of contract by a counselor whose heavy field schedule in addition to his office schedule limits the promptness with which he can respond to such client needs.

SERVICES SHOULD BE MADE AVAILABLE TO BLIND CLIENTS AS EARLY AS POSSIBLE FOR THE PREVENTION, TREATMENT AND REHABILITATION OF BLINDNESS. A FOLLOW-UP SERVICE IS NEEDED FOR ALL PERSONS STARTING FROM BIRTH AND GOING THROUGH RETIREMENT WITH CUMULATIVE REPORTS PROPERLY MAINTAINED BY BOTH PUBLIC AND PRIVATE AGENCIES. PRIORITY: ESSENTIAL

WE RECOMMEND THAT PROVISIONS BE MADE FOR A PERIODIC HEALTH EXAMINATION, WHICH WOULD INCLUDE AN EYE EXAMINATION, FOR ALL INSTITUTIONALIZED AGING PERSONS. PRIORITY: URGENT

A health examination would be part of a total service program to prevent deterioration which is essential in dealing with the aging. It is felt that an eye exam is often overlooked and is considered primarily in terms of visual acuity rather than eye pathology.

IT IS RECOMMENDED THAT THE SOCIAL SECURITY DISABILITY EARNINGS CEILING OF $1,680 BE RAISED OR REMOVED FOR ALL DISABLED PERSONS WHO HAVE BEEN CERTIFIED AS BEING CAPABLE ONLY OF WORKING IN THE SPECIAL WORKSHOP. PRIORITY: DESIRABLE

Raising or removing the Social Security disability ceiling would allow each client to work to his fullest capacity with a resultant increase in earnings and a resultant increase in income tax for the federal government, as well as a possible diminution of blind persons in the special workshop who are now on welfare rolls.

At the present time there are many blind persons employed in special workshops who receive Social Security disability benefits. With the present earnings ceiling, most of the employed clients are forced to limit their earnings in order to avoid earning over the $1,680 ceiling or jeopardize their benefits. This creates a problem for the client who so often feels guilty about his obvious attempts to slow down and also makes it difficult for the workshop to meet production schedules. In order to meet production schedules, the workshop would have to provide employment for a much greater number of part-time employee clients even if such numbers were available. This is usually not feasible because of limited space, and most importantly, limited funds with which to provide the additional necessary services to a larger total group of employees that would be required.

WE RECOMMEND THAT THE GOVERNMENT, BE IT STATE OR FEDERAL OR BOTH, PROVIDE A WAGE SUBSIDY FOR CLIENTS IN THE SHELTERED WORKSHOP IN ORDER TO PROVIDE THEM WITH THE MINIMUM WAGE. PRIORITY: ESSENTIAL

The subsidy would be added to the individual client's actual wages. The workshop would have the responsibility to show the difference between the client's earnings and the statutory minimum wage, with the difference becoming the wage subsidy. It should be noted that controls would have to be initiated in order to determine what the client's earnings would be, based on fair and equitable piece rates. It is not realistic to expect the special workshop, which must operate at a financial loss if it is to employ the least employable, to add to the financial burden the cost of paying each employed client the statutory minimum. This would obviously make the costs of operation prohibitive and completely uncompetitive.

WE RECOMMEND THAT THE PRESENT SYSTEM OF DETERMINING THE EFFECTIVENESS OF A COUNSELOR'S WORK BE REEVALUATED THROUGH THE DEVELOPMENT OF A "WEIGHTING SYSTEM" AND WHICH WOULD PROVIDE A MORE REALISTIC BASIS FOR THE ASSESSMENT OF THE COUNSELOR'S PROFESSIONAL EFFORT. PRIORITY: DESIRABLE

At present the successful case closures of a counselor may be overly emphasized as the hallmark of effectiveness. A "weighting system" should be developed which would attempt to assign a specific point score to each case in terms of the effort that may be anticipated to achieve a successful conclusion. Such a weighted caseload would reflect more realistically the professional inputs required and would ultimately be reflected in closure.

IN ORDER TO DEVELOP SUITABLE JOBS FOR THE BLIND IN COMPETITIVE INDUSTRY AS A COUNTERPART OF SERVICE, THE STATE AGENCY SHOULD SET UP IN ITS LOCAL ORGANIZATIONAL STRUCTURE A PLACEMENT AND EMPLOYMENT CONSULTANT. PRIORITY: DESIRABLE

A placement and employment consultant would work with the rehabilitation counselor on specific cases to develop job leads, contact employees, follow-up placement, and maintain liaison with the State Employment Service and local employment sources. There must be a closer relationship with the State Employment Service, for example, to emphasize the placement of capable blind and other handicapped individuals in competitive industry. The placement and employment consultant would also develop an extensive public education and information service with the employing community. The ultimate responsibility for placement, however, would continue to rest with the rehabilitation counselor serving the case. The blind, unlike other disabled, require greater community and employer education to help them recognize the capacity of the blind person when properly trained. The employer could also be helped to make job changes with respect to his blind employees if he could have the services of a consultant.

THE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED, AS WELL AS THE PRIVATE AGENCIES SERVING THE BLIND, SHOULD EXPAND RECRUITMENT EFFORTS TO ENCOURAGE INDIVIDUALS, BEGINNING AT THE HIGH SCHOOL LEVEL, TO ENTER THE FIELD OF SERVICES FOR THE BLIND. PRIORITY: DESIRABLE

Recruitment should be the responsibility of both state and private agencies.

Deaf-Hearing and Speech

WE RECOMMEND THE RECRUITMENT AND EMPLOYMENT OF PERSONNEL TRAINED IN COMMUNICATION WITH PERSONS WHO HAVE AUDIO-COMMUNICATIVE DISABILITIES AND WHO HAVE IN ADDITION, SUFFICIENT PROFESSIONAL UNDERSTANDING TO EXPLAIN TO THE SERVICE AGENCIES WHAT THE CLIENT WANTS, AND EXPLAIN TO THE CLIENT WHAT SERVICES AGENCIES CAN PROVIDE. PRIORITY: URGENT

There is an almost complete lack of professionals and paraprofessionals on the staff of or available to specialized or generic rehabilitation agencies, health and mental health agencies, rehabilitation diagnostic and training facilities, halfway houses, sheltered workshops, etc. who are capable of communicating with and serving the needs of many deaf persons, especially those with multiple handicaps.

Personnel who would act as translators or interpreters should be consultants available to several agencies in a particular community or several county areas, and have a work schedule flexible enough to meet his own agency responsibilities and act as a consultant. The cost of a consultant could be supported, for example, by a community council. The consultant must have additional helping skills, and a measure of service training so he would know how to interpret to the professional and translate nuances to the professional and the client.

INTER-DISCIPLINARY DIAGNOSTIC TREATMENT CENTERS FOR COMMUNICATION-IMPAIRED SHOULD BE DEVELOPED THAT WOULD BE CAPABLE OF DIAGNOSING AND TREATING COMMUNICATIONS AND LEARNING PROBLEMS. PRIORITY: URGENT AND LONG-TERM

Centers may be part of a comprehensive medical care center but should have a capacity for education as well as medical diagnosis and prognosis. The scope of the center should involve development, corrective and remedial problems and offer communication skills training and language development services. The center could also be placed in existing hearing and speech centers, but wherever possible the treatment centers should be located in areas which are remote from existing resources. An important part of a diagnostic treatment center would be mobile facilities for testing and treatment of hearing and speech impaired. This form of outreach would accelerate the goal of having all persons needing rehabilitation services actually receiving them by 1975.

BETTER COMMUNICATION AND COORDINATION MUST BE DEVELOPED BETWEEN MEDICAL SPECIALISTS IN THE DIAGNOSIS AND TREATMENT OF THE DEAF, HARD OF HEARING AND SPEECH IMPAIRED. PRIORITY: URGENT AND LONG-TERM

Specifically, there should be better communication between surgeons and speech pathologists for proper preparation for esophageal speech prior to surgery for the laryngectomized. Generally, several things might be considered: provide medical specialists with lists of orientation to other medical specialists in the field such as otologists, otolaryngologists, ophthalmologists, psychologists, speech therapists and remedial reading specialists; include an understanding of communication disabilities in medical school training with doctors trained early in their studies to be aware of the total functioning of a handicapped person as well as the emotional implication of a handicap for the individual, his family and social environment; and provide information on the various public and private programs and services which these resources afford for the communications impaired. County central clearing house and referral agency personnel would be appropriate persons to facilitate better communication as part of their community organization, public education and resource consultant roles.

FOR COMMUNICATIONS IMPAIRED CHILDREN WHO ALSO HAVE PHYSICAL DISABILITIES, COMPREHENSIVE SERVICE IS RECOMMENDED. COMPREHENSIVE SERVICE SHOULD INCLUDE PSYCHIATRIC SERVICES, CASE WORK, PSYCHOLOGICAL AND EDUCATIONAL THERAPY AND A THERAPEUTIC NURSERY. PRIORITY: ESSENTIAL

Comprehensive service centers should be established in easily accessible areas. The center's therapeutic nursery, for example, would provide a method for early identification, a program of behavior modification, and developmental acceleration for infants and pre-nursery age children identified as high risk cases.

CORRECTIONAL REHABILITATION

Provision for rehabilitation of the public offender represents a new area of service under Public Law 89-333, the 1965 Amendments to the Vocational Rehabilitation Act. The Task Force Corrections Committee recognizes the problems inherent in this new area of service, yet underscores communication between professions and disciplines as a sine qua non for effectively overcoming problems. A continued absence of mutual interest, gaps in awareness of parallel services, different language or jargon, approach, philosophies and attitudes postpones the application of community services to available client populations. The committee also sees as essential the extension of rehabilitation services in and out of institutions, and establishing a clear definition of disability.

Social Disability and Eligibility

The establishment of a disability through a clear delineation of syndrome, diagnosis, etiology and treatment, although feasible for many disability groups, is not applicable to the disabling factors which hamper the public offender. The public offender clientele is heterogeneous as to age, sex, physical status, ethnic group, intelligence, and psychiatric condition. Their disability is primarily social. Public attitudes, the attitude of the employer, and legal restrictions imposed on ex-prisoners, although they cannot be quantified in the same manner as a hearing loss, do exist and do constitute impediments to employment.

Examples of restrictions include these:

- certain offenders known to the State Division of Parole cannot accept employment in licensed liquor establishments without permission of the State Liquor Authority;

- the State Motor Vehicle Department automatically revokes the drivers license of a convicted felon;
- Civil Service employment opportunities are often denied offenders;
- legal bars to entering some professions and voting are incurred due to felony convictions;
- the Division of Vocational Rehabilitation services do not reach many offenders who are socially handicapped persons. For example, according to the records of the New York State Division of Parole, New York State Probation Department and the Nassau County Jail, of 11,137 clients served by the Nassau County Jail, although 5,619 were seen as handicapped for employment, only 102 were referred to the Division of Vocational Rehabilitation and 217 referred to other agencies. In Region II, public offender statistics include: new commitments to state correction institutions in 1965, 686; prisoners admitted to county jails in 1966, 12,925.

Although it is recognized that the offender in a correctional institution is provided with constructive services, his reinvolvement tends to compound his social disablement.

Agency Functions and Approach

Each of the correction institutions performs a distinct service, and each exists for a different, though interrelated purpose. The priorities of probation are, first, to effect pre-sentence investigations requested by the criminal courts and the family court, and second, to "supervise" those citizens whom the court places under probation's jurisdiction for rehabilitation. The goals of parole are to protect the community and to improve the community integration of the parolee, thus serving as a bridge between penal institutions and the community. The jail is a holding institution for those who are sentenced, or for those awaiting legal action and it places high priority on security. All agencies avow the importance of rehabilitation and use a variety of techniques to effect integration of those serviced in the community.

The priorities of correction agencies, however, are somewhat at variance with the priorities of client-centered agencies. The contrast between the social worker's approach and the approach of the policeman is analogous to the different "tone" of approach to clients by the client-centered agencies and the approach by the correction agencies.

Rehabilitation connotes to the public, for the most part, a positive process of mobilizing an individual's strengths so that he can be effectively used in the community. The cerebral palsied, the blind, the orthopedically impaired, the retarded and other groups have had a measure of sympathy, empathy and hope afforded them by the community. The public attitude towards rehabilitation of offenders involves not only feelings towards a "person with problems," but with moral values and behavior standards as embodied in the law. Public and personal safety, and the element of fear make the tone of public opinion quite different when the term "rehabilitation" is used with the offender.

Rehabilitation counselor training in graduate schools such as New York University, Hofstra, etc., is geared toward rehabilitation of the physically disabled, the retarded, and the psychiatrically disabled. The spectrum of professional skills acquired is not extensive in the area of social disability; offenders and ex-offenders are considered in a superficial manner.

The following recommendations reflect suggestions which the community hopes will remedy some of the existing conditions.

THERE IS A DEFINITE NEED FOR EXPOSURE OF PROFESSIONALS WORKING IN CORRECTIONS AND IN VOCATIONAL REHABILITATION AGENCIES TO THE PHILOSOPHIES, ATTITUDES AND TERMINOLOGY OF EACH OTHER. PRIORITY: ESSENTIAL

> Mere inter-agency referral does not effect a continuity of service for the client -- there is a need to study the value of utilizing staff from one agency in another agency, both for liaison and professional instruction. The team approach is essential.

THERE IS A NEED FOR BETTER LIAISON BETWEEN THE DIVISION OF PAROLE AND THE DIVISION OF EMPLOYMENT TO HANDLE THE POORLY MOTIVATED MINORITY POPULATION THEY BOTH SERVE. PRIORITY: DESIRABLE

> Cooperative guidelines for responsible and effective services will more likely result in better job training and placement for this group. The mechanics of agency operation often serve as defenses against innovations and inter-professional communications, and thus, the mechanics of client screening and client processing become, to all intents and purposes, that which constitutes the profession of "rehabilitation counseling" and "corrections."

RESEARCH IS NEEDED IN ORDER TO ASCERTAIN THE TYPES OF DISABILITIES WHICH BRING CLIENTS TO CORRECTION AGENCIES AND WHICH DISABILITIES ARE VOCATIONALLY HANDICAPPING. PRIORITY: DESIRABLE

Data is not currently available which would show that corrections clients could be grouped into a single type of social disability or whether a number of different social disabilities handicap different clients.

RESEARCH IS ALSO NEEDED TO DETERMINE WHETHER SOME MEDICAL DISABILITIES ARE MORE PREVALENT AMONG CORRECTIONS CLIENTS THAN OTHERS. PRIORITY: DESIRABLE

Officers at the Nassau County Jail, for example, suspect that there is a much higher proportion of epileptics in the jail population than in the population at large. Research can be effective in establishing a valid and reliable estimate of the nature of the disabilities suffered by corrections clients.

THERE IS A NEED FOR COMMUNICATION BETWEEN THE OFFICE OF STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION SERVICES AND THE GOVERNOR'S SPECIAL COMMITTEE ON CRIMINAL OFFENDERS. PRIORITY: URGENT

Efforts of the Office of Statewide Planning and the Corrections Task Force have proceeded independently of a survey conducted by the Governor's Committee. Both groups are making proposals for client services and inter-agency cooperation, both are funded by the state, yet they are working independently.

WE RECOMMEND THAT THE NEW YORK STATE DIVISION OF PAROLE PROVIDE EXTENDED CONSIDERATION FOR CERTIFICATES FOR RELIEF FROM DISABILITIES TO INCLUDE ALL OFFENDERS RATHER THAN LIMITED TO FIRST OFFENDERS. PRIORITY: URGENT

WE RECOMMEND THAT STATE LIQUOR AUTHORITY RESTRICTIONS FOR EMPLOYMENT OF OFFENDERS ON LICENSED PREMISES BE REVIEWED TO PROVIDE JOBS FOR OFFENDERS. PRIORITY: URGENT

The policies of the Alcoholic Beverage Control Division place stumbling blocks in the path of job placement for probationers and parolees. Restrictions are placed on place of work and on license even though these two factors may be primary to adequate job placement of offenders.

SINCE THE MOTOR VEHICLE DEPARTMENT AUTOMATICALLY REVOKES DRIVERS LICENSES OF CONVICTED FELONS, IT IS RECOMMENDED THAT THIS PRACTICE BE REVIEWED AND CHANGED TO PROVIDE JOB OPPORTUNITIES FOR OFFENDERS BY REMOVING THE NECESSITY OF AUTOMATIC REVOCATION OF DRIVERS LICENSES OF CONVICTED FELONS. PRIORITY: URGENT

SINCE CIVIL SERVICE EMPLOYMENT OPPORTUNITIES ARE LIMITED TO OFFENDERS, IT IS RECOMMENDED THAT THIS PRACTICE BE REVIEWED AND CHANGED TO PROVIDE JOB OPPORTUNITIES FOR OFFENDERS. PRIORITY: URGENT

WE RECOMMEND THAT HOSTEL FACILITIES FOR THOSE IN NEED OF HOUSING ON RELEASE FROM PRISON BE PROVIDED. PRIORITY: URGENT

The use of intermediate housing will facilitate rehabilitation and also possibly deter future offenses.

WE RECOMMEND THAT MORE HOSPITAL BEDS FOR TREATMENT OF DRUG ADDICTS SHOULD BE PROVIDED. PRIORITY: CRITICAL

This need is critical and urgent as drug usage increases.

WE RECOMMEND THAT MORE EXTENSIVE PSYCHIATRIC AND PSYCHOLOGICAL SERVICES BE PROVIDED TO THE PUBLIC OFFENDER. PRIORITY: ESSENTIAL

There is a concern that many in this group have mental problems.

THERE IS A NEED FOR SPECIAL PROGRAMS FOR THE "HARD CORE" YOUTHFUL OFFENDERS WHO LACK BASIC EDUCATION, MANUAL SKILLS AND DESIRE FOR HELP. PRIORITY: ESSENTIAL

Programs would include remedial reading and special education classes near or in Division of Parole offices, Division of Vocational Rehabilitation counselors could work within the Division of Parole offices, and in the penal institutions the classes would include socially handicapped offenders.

IN THE NASSAU COUNTY PROBATION DEPARTMENT WE RECOMMEND THAT A PROBATION RESIDENTIAL CENTER AND PROBATION WORKSHOP FACILITY BE ESTABLISHED. PRIORITY: URGENT

A center and facility would provide a residential treatment center for short-term treatment of selected probationers who would live at the center while spending their day-time hours undergoing vocational education or training outside the center. In addition, treatment at the center would include the services of a psychologist and vocational guidance counselor. Individual and group counseling sessions would also be a major part of the center's program.

A tentative staffing recommendation for the probation residential center would include director, assistant director, psychologist, three caseworkers, two steno-clerks and a cook at an annual salary of approximately $80,500. The purchase price of a facility to house a maximum of 25 persons would be about $150,000 and operating costs, annual estimate, $45,625.

A tentative staffing recommendation for a probation workshop facility would include a supervisor and a work-employment counselor at a total estimated cost of $17,000. The cost for renting or purchasing space for a workshop program for approximately 25 short-term clients would depend on the size and location of the proposed residential center. Tentative plans call for incorporating both facilities in one building, with the cost of initial equipment at $10,500 and operating costs, annual estimate, $10,000.

The probation workshop would be a work-sample testing type of workshop at or near the proposed residential center. Its use, however, would not be restricted to those probationers residing at the center but would be open to all clients of the probation department. The purpose of the workshop would be work evaluation and personal adjustment training in three general industrial areas — clerical, electronic and machine shop.

Probation officers would counsel probationers in the residential center and engage actively in the prevocational evaluation process. The probation staff development unit would utilize the services of staff social workers, psychiatrists, and others to strengthen the skill of the probation department in dealing with the vocational problems of clients in and out of the center.

WE FURTHER RECOMMEND THAT A VOCATIONAL FACILITY PROVIDING TRAINING IN INDUSTRIAL AND CLERICAL AREAS BE ESTABLISHED IN THE NASSAU COUNTY JAIL. PRIORITY: ESSENTIAL

The staff would include a psychiatrist, vocational guidance counselor, and five vocational instructors at an estimated staffing and equipment cost for the first year of $100,000 and subsequently, $75,000 per annum.

IT IS RECOMMENDED THAT HALF-WAY HOUSES BE ESTABLISHED IN WESTCHESTER COUNTY FOR MEN LEAVING THE PENITENTIARY WHICH WOULD PROVIDE RESIDENTIAL ACCOMMODATIONS AS WELL AS SUPPORTIVE SERVICES. PRIORITY: ESSENTIAL

IT IS RECOMMENDED THAT VOCATIONAL REHABILITATION SERVICES BE MADE AVAILABLE TO THOSE IN THE WOMEN'S PENITENTIARY AND THE MEN'S JAIL. PRIORITY: URGENT

IT IS FURTHER RECOMMENDED THAT TREATMENT CENTERS BE ESTABLISHED BY THE STATE DEPARTMENT OF MENTAL HYGIENE OR COMMUNITY MENTAL HEALTH BOARDS FOR THOSE ARRESTED FOR ALCOHOLISM AND THAT THE TREATMENT CENTERS WOULD PROVIDE PHYSICAL AND VOCATIONAL REHABILITATIVE SERVICES. HIGH PRIORITY

Men and women who have served their sentences and are ready to return to society frequently have no families to whom they can go, no place to stay, and no jobs. If they are to make a successful readjustment to society, they need supportive help of various types for at least a temporary period.

The population at the penitentiary in Westchester is approximately 200 with a turnover of approximately 2200 during the course of the year. It is estimated that 5 percent of the population are "feeble-minded." Forty percent are alcoholics, 35 percent are narcotic addicts and about 20 percent are listed as "others."

The women's jail which houses both those awaiting trial and those serving short-term sentences handles approximately 250 during the year and the population varies from ten to over 20. They are imprisoned for alcoholism, shoplifting, forgery, narcotics, abortion, disorderly conduct, etc.

Under the provisions of the new penal law, the alcoholic serves a maximum sentence of 15 days and other inmates may serve as much as a year. The average sentence is approximately two to three months. The 15-day sentence for alcoholics is not long enough for the intensive care which was previously given in the penitentiary and does not give time to build the men up physically. They are returning to the penitentiary after a short stay in the community and are not in condition to do the physical work formerly done by the alcoholics. The women in the jail have never been given any of the treatment services given the men in the penitentiary and the women alcoholics have no help from AA.

There is an immediate need for a half-way house program for men leaving the penitentiary. Hawthorne House located in White Plains has beds for 12 men but is meant for persons other than those coming from the penitentiary. A second half-way house for alcoholics is soon to be set up in Yonkers and will accommodate 35 men alcoholics. Accommodations are needed, however, for more than the alcoholics where former inmates could obtain lodging, food and help in getting employment. The men would be permitted to remain there temporarily and would contribute to their support from any earnings they might have.

The cost of a half-way house varies according to the staffing and services provided. Most houses, if they are to meet the needs of former prisoners, cannot attempt to be self-supporting as Hawthorne House aims to be. The cost is estimated to be about $2,000 a bed for a half-way house with only the most essential staffing to $8,000 a bed per year for a house with psychiatric services, group counselling, vocational training (not necessary if Manpower Development Training Programs are available) and management staff.

It is reported that funds for half-way houses may be available through the federal government. The cost for temporary shelters of this type, even if high, is considerably less than the cost to society of men returning to crime.

A half-way house for women prisoners from jail, if confined to those who have been in the Westchester Jail, would not seem justified at present as very few are released at a time, but after-care supervision is greatly needed.

THE DEPARTMENT OF CORRECTION, THE DIVISION OF VOCATIONAL REHABILITATION, AND THE NEW YORK STATE EMPLOYMENT SERVICE SHOULD EXPLORE THE NEED FOR A WORK RELEASE PROGRAM IN THE PENITENTIARY TO FACILITATE REHABILITATION OF OFFENDERS. PRIORITY: ESSENTIAL

Work release programs, which permit prisoners to work in the community during the daytime and return to the institution at night, have been successfully experimented within different sections of the country. In the 1968 session of the New York State Legislature, four bills were introduced to permit work release programs, each one applying to a different type of correctional institution - the five penitentiaries, the jails, New York City correctional institutions, and the state prisons. All of the bills with the exception of the one affecting state prisons became law.

Work release has many desirable features. It permits some to be trained for employment in the community and others to retain their jobs. Prisoners upon release may not then have a period of rejection, of employment problems and lack of funds. A careful selection of those granted this privilege must, of course, be made.

Certain factors might affect the success of such a program in Westchester County which would not apply in all sections of the state however. Westchester County industries are widely scattered over a very large area. The penitentiary has no industries nearby and transportation would be a serious problem. Also, transportation within the county is inadequate.

Other means now exist to relieve the problem of employment for those sentenced to the penitentiary. Certain judges have sentenced men to weekends in the penitentiary but have permitted them to work in the community during the daytime. Recently a new program called "Vocational Opportunity Training" has been introduced at the penitentiary where the inmates under experienced supervision can learn skills which fit them for employment — maintenance work, plumbing, electrical work, tailoring, the handling of food, etc. In addition, they are to receive guidance and counselling in the evening and training in the discipline and attitudes necessary to keep a job. This type of training seems to be needed by a very large number of the prisoners and the lack of it may well be one of the reasons for their being in the institution.

Others interested in the problem of employment of prisoners have suggested that if a man is considered reliable enough to go out to work in the community, he should have been put on probation rather than sentenced to a correctional institution. If this is tried for a large number of offenders, an adequate probation staff, both in numbers and training, would be necessary because of the need for careful and close supervision of the workers.

A RELEASE ON OWN RECOGNIZANCE (ROR) PROGRAM SHOULD BE ESTABLISHED BY THE DEPARTMENT OF PROBATION AND THE COURTS TO ENABLE THE INDIGENT ACCUSED TO RETURN TO FAMILY AND GAINFUL EMPLOYMENT WHILE AWAITING APPEARANCE IN COURT. PRIORITY: ESSENTIAL

The bail system as it now operates causes serious inequities. The indigent accused are held in jail awaiting trial while defendants with money, and many of these may be professional criminals, may circulate freely in the community. The man unable to make bail may lose his employment while he is imprisoned and his family may have to go on welfare. He is also unable to locate witnesses or consult with counsel.

The Manhattan Bail Project conducted by the Vera Foundation in cooperation with the New York University of Law and the Institute of Judicial Administration proved that men who had roots in the community, a family, a job, and a residence would turn up for their appearance in court and did not need to be detained in jail. Considerably over 90 percent of those who had been investigated and judged to be good risks appeared in court at the required time - more than the proportion of those who had paid bail. Men charged with certain serious felonies were excluded from the experiment.

Four years ago, members of the Westchester Citizens Committee of the National Council on Crime and Delinquency, examined the records of the prisoners held in the Westchester jail during a three month period. It was found that many of the prisoners had been held in the jail for several months. When brought to trial, some were found to be innocent, others were released on probation, and still others were given suspended sentences. The disposition of these cases clearly indicated that instead of idling away their time in jail they could have been in the community where they might have been gainfully employed.

These findings led to the Westchester Probation Department setting up a limited ROR project for those appearing before the county court. On account of the decentralization of the local courts (Westchester has 46 local courts), it was not possible to institute the practice without a very large staff, even had the magistrates been willing to put it in operation.

There is need for improving the operation of ROR in the county court in Westchester and for a wide education campaign to inform local magistrates of its desirability both from the point of view of equal justice and economic advantages. Many judges have lost sight of the fact that the sole purpose of bail is to assure an accused person's appearance in court and instead regard it as a means of punishment. The task of informing the judges and of operating this reform would be greatly simplified should the lower courts be consolidated and a district court such as that in Nassau and Suffolk Counties be established.

A PILOT MODEL LIBRARY PROGRAM SHOULD BE ESTABLISHED IN ONE WESTCHESTER COUNTY PENITENTIARY. PRIORITY: ESSENTIAL

Adequate library service is an essential part of educational and rehabilitative programming for correctional institutions. Unfortunately in Westchester County the facilities in the penitentiary are very inadequate and no library facilities are available for the men's or women's jails. Woodfield, the detention home for young people, which is under the Department of Social Services, is also sadly lacking in appropriate facilities of this type.

In a position paper on correctional institution libraries, Miss Marion H. Vedder, Associate in Institutional Library Services of the New York State Department of Education, states:

> Libraries in a correctional situation have a clear responsibility to support, broaden and strengthen the institution's total rehabilitation program . . . . The library program should provide an opportunity for education, information and recreation.

Miss Vedder also mentions the need for vocational information, planned reading courses geared to individual needs, and materials used for the psychologist, the educational program and staff members.

The Westchester penitentiary now has two programs: basic education, and high school equivalency training. In addition, a vocational opportunity training program is planned and if the approval of the Board of Supervisors is obtained, it will be set up shortly. These programs are supported with federal funds and administered through the New York State Department of Education. The vocational program will be operated by BOCES, the basic education program by the Adult Education Division of the White Plains Board of Education, and the high school equivalency program is under a staff member appointed by the State Department of Education. These developments have come from a successful demonstration program financed and operated by the Westchester Citizens Committee of the National Council on Crime and Delinquency. The State Department of Education and the Commission on Corrections are working together to extend similar programs to other correctional institutions with short-term prisoners.

An adequate library service is a much needed supplement to the educational programs now operating. Should the educational programs be extended to the men's and women's jails under the Department of Correction which will be set up in Westchester on January 1, 1969, library services would be even more valuable. By experimenting in this service, Westchester might again be helpful in encouraging other institutions in the state to improve their facilities.

A TREATMENT CENTER FOR ALCOHOLICS ARRESTED FOR PUBLIC INTOXICATION SHOULD BE SET UP AT GRASSLANDS HOSPITAL, IN WESTCHESTER COUNTY, UNDER THE RESPONSIBILITY OF THE COUNTY COMMUNITY HEALTH BOARD OR STATE MENTAL HYGIENE DEPARTMENT. PRIORITY: ESSENTIAL

According to an article in a newsletter published by the Correctional Association of New York (September, 1968) in Monroe County, some of the men charged with public intoxication may now be given a conditional discharge rather than a prison term and sent to a treatment unit in the county hospital.

An individual is admitted to the treatment program either voluntarily or through direct recruitment at the county or city court where he is awaiting action on public intoxication or other "alcoholism-linked charges." After the judge grants the conditional discharge, the individual takes part in a treatment program operated in the county hospital. The discharge is recommended only after the man has been through detoxification and has been found through tests and observation to be responsive to treatment. The program is an interdisciplinary one, involving rehabilitation, mental health, social welfare and correctional resources. The stay in the institution is usually about two months, and during this period the Division of Vocational Rehabilitation services are used for the occupationally handicapped.

It would seem possible to have such a center established in the Grasslands Hospital in Westchester. A recommendation for a treatment center at the county hospital was made in 1962 by the County Executive Committee on Alcoholism.

The 15-day maximum sentence for those who are charged with public intoxication and no serious crime means that any program set up in a penitentiary is ineffective. Realizing this, the State Department of Mental Hygiene has established a treatment center for alcoholics near Utica. It is also reported to have included requests for funds last year which would have made it possible to set up a number of such centers. The funds were not granted. Should such requests be made again for the 1969 budget, public support should be given for the establishment of treatment centers for alcoholics.

THE DISADVANTAGED - SOCIAL AND ECONOMIC DISABILITY

Mary E. Switzer, Administrator of the Health, Education and Welfare, Social and Rehabilitation Service, in a letter greeting the Region II National Rehabilitation Conference states:

> These are challenging days for rehabilitation. The urgent needs of those who are living in poverty, particularly in our urban ghettos, call on all of us for our most creative ideas and devoted efforts to reach those who have not been reached, to reshape our programs wherever necessary to make them more sensitive and responsive to the needs of the poor, and to extend our endeavors beyond the physically and mentally disabled to all who need the help that rehabilitation can offer.
>
> This is a great challenge. But we have met great challenges many times before.
>
> With your dedication and your skills, I am confident of our success.

Her statement supports and extends Section 15a of Public Law 90-391 of July 1968, amending the Vocational Rehabilitation Act to provide rehabilitation services to the disadvantaged as well as the disabled.

We feel that the highest priority should be given to increasing rehabilitation or habilitation services to the socially and economically deprived.

The Vocational Rehabilitation Amendments of 1968 recognize that the area of the socially and economically disabled — perhaps best termed the disassociated — could benefit greatly from a comprehensive planned program involving the Division of Vocational Rehabilitation.

As far as physical rehabilitation is concerned, there is no reason why every physically handicapped person should not be restored to the highest degree possible.

The job in social habilitation and rehabilitation is enormous, but it can be done. It is not as simple as it is in physical rehabilitation; more time, more money, more understanding, more patience must be given to each individual. Realistic personal, social and financial incentives must be made available. Full involvement and participation into the main stream of society must be offered.

Many of the individuals who work in the area of physical rehabilitation or mental rehabilitation and vocational counseling must reorient themselves and be retrained if they are to be effective in working with the socially and economically deprived. They must identify with the group they are to serve. A bias, no matter how subtle, is quickly recognized. The term motivation must be redefined or, perhaps, discarded. In physical rehabilitation the desire to regain former patterns of living is "motivation" enough. In social rehabilitation "motivation" has to include presentation of advantageous and concrete salary and work objectives, and improved self-image. Above all, the goals of the clients must be understood, particularly when they represent unfamiliar cultural patterns. The utilization of indigenous paraprofessionals is an effective way to deal with "culture shock." The rehabilitation approach is already utilized by industry in C.A.M.P.S. in the problems of the socially disabled and handicapped.* Application and techniques of practitioners must go through a reexamination; this should no longer be postponed.

It would be important to know the reasons why so many socially and economically deprived clients are not accepted by the Division of Vocational Rehabilitation, and more importantly, what the procedure is for official or unofficial scrutiny and analysis. The agency policy states that clients are not accepted only when they have been found ineligible for service and that the counselor's certificate of ineligibility must be reviewed by the supervisor for approval or disapproval. When a client is declared ineligible, he is informed of his right to appeal this decision.

All of us are well aware that even the most comprehensive and fully implemented plans can come to a halt when an individual or family seems reluctant to take advantage of them. Although there seems to be individual situations that appear hopeless and possibly are not responsive to rehabilitation, under cold analysis the reluctant and hopeless individuals are usually few in number. More often we find that virtually every individual "can be reached" and will want to participate if the opportunity and rewards are understood.

The suburban poor of Region II, for example, have little political power because they live in pockets of poverty rather than in huge concentrations located in cities. The lack of low-cost housing and inadequate public transportation are common needs.

In affluent Westchester and Nassau, as well as less affluent Suffolk and Rockland, there are disparate pockets of poverty. This metropolitan area reports 99,683 persons receiving welfare as of June, 1968, or 3.5 percent of the population. Suffolk County has the greatest number of migrant workers and the lowest per capita income of the four counties. In Westchester, the cities of Mount Vernon and Yonkers have nearly 7,000 families living in abject poverty with an income under $3,000 per year. The rest of the county, including Tarrytown and Larchmont, account for almost 7,500 families in abject poverty. More than 50 percent of all black families in Westchester are deprived. In Suffolk, 25,000 to 30,000 families live in poverty— one out of four black families and one out of ten white families.

In these counties the delivery of community services to the poor or socially disabled is mainly lacking, despite chilling popular beliefs that "handouts" are prevalent. In Westchester, for example, where ten percent of the population lives in abject poverty, only two percent were on the public welfare rolls in May, 1968.

In Suffolk, the unemployment rate is at five percent, twice that for Nassau County. Poverty is a reality for one of nine families in Suffolk, probably representing about 25,000 to 30,000 families; approximately 8,000 families are on welfare. In Suffolk, one of every four non-white families is poor, while one of ten white families is impoverished. More than half the impoverished families are elderly couples or families with female heads of household, without wage earners. The white poor are likely to be elderly and retired and living in their own homes. The black poor are younger, with children, jobless or unemployed, living in rented quarters within a ghetto.

Suffolk County has used the Title V Program sponsored by the federal government to demonstrate the advantage of transforming consumers of public wealth into producers of private wealth.

---

*See interview at Grumman Aircraft Engineering on p. 218

Responsibility for providing jobs, housing, education and health ultimately as well as initially belongs to the total community. Time is running out on postponement, avoidance, and overt denial of this responsibility. Our national crisis in this area is only an aggregate of all the Westchesters, Suffolks, Nassaus and Rocklands all over our land. Advocacy, outreach and service delivery, implemented and relevant, must be universally extended to the catastrophically disadvantaged.

The following recommendations encompass training in several areas including college, high school dropout, remediation, prevocational and vocational; sensitivity training for personnel; a closer relationship between the school and rehabilitation services; the coordination of services in a multi-service center; and coordination and/or pooling of existing services to reach more persons in need. New service areas relate to job adjustment counseling in industry. Transportation problems are approached by a unique plan to utilize the disadvantaged to aid the disabled. The use of job analysis to facilitate training and placement of paraprofessionals is urged. Community responsibility is reaffirmed by a commitment to implement these recommendations.

IT IS RECOMMENDED THAT AUTONOMOUS MULTI-PURPOSE NEIGHBORHOOD CENTERS BE ESTABLISHED, OPERATED BY EXPERTS WHOM THE RESIDENTS OF THE NEIGHBORHOOD EMPLOY. HIGH PRIORITY

In addition to employment and job training, there would be other services, e.g., health, social service and mental health which the center would maintain in a working relationship with Division of Vocational Rehabilitation, industry, health agencies and social services. It would provide for the localization of services.

WHILE WE ARE NOT PREPARED AT THIS POINT TO MAKE ANY LARGE CLAIMS OF SUCCESS, WE DO BELIEVE THAT OUR EXPERIENCE IN SENDING YOUNG PEOPLE WITH POOR PREPARATION TO COLLEGE HAS DEMONSTRATED ENOUGH MERIT TO WARRANT A FOUR OR FIVE YEAR PILOT PROJECT ADEQUATELY FINANCED TO PROVIDE SUFFICIENT COUNSELING AND ADMINISTRATION PERSONNEL TO PLACE STUDENTS PROPERLY, GIVE THEM ADEQUATE SUPPORT AND EVALUATE THE RESULTS. PRIORITY: URGENT AND CRITICAL

After this period, the project may very well develop guidelines which will be applicable to the solution of similar problems elsewhere in the nation.

The basic purpose of the Neighborhood Youth Corps of the Westchester Community Opportunity Program, Inc., is to motivate young people between the ages of 16 and 22 who are from the lowest socio-economic group in the nation to acquire a high school diploma and a job with upward mobility, or to secure vocational training which will give them the skills necessary to hold a job where they will earn enough to break the cycle of poverty.

However, the Neighborhood Youth Corps program discovered that this objective was so low that it failed to inspire most of the young people. They could make as much money hustling on the street corner as they could at a gas station or dry cleaning shop. And the street corner was more exciting.

The problem was to find some way of motivating these young people to prepare themselves to become contributing members of our society. Thus the College Careers Program was devised. The reasoning was simple. If higher education is good for the middle income student of average ability, then it ought to be equally good for the lowest socio-economic group. In fact, it ought to be better. There is nothing that opens up new career possibilities, new ways of living, and creates new attitudes towards society quite so readily as education. The College Careers Program is a reclamation and rehabilitation program intended to find out if a college education can ameliorate severe environmental limitations and prepare socially and culturally deprived young people to play a responsible role in the American society.

The chief difficulty was that most of these young people had poor preparation, almost no motivation, no self-confidence, no money, no family encouragement, and police records. The job of the Youth Corps Program was to convince them that these obstacles were not insurmountable.

As a result of effective counseling to persuade young people to give college a try, and after a grueling community campaign to raise the necessary funds, 63 young people were sent to 23 different colleges last September. Of these 63 students, 54 completed the first year and 7 others will probably start again this fall. The cost is approximately $2,000 per student.

The Division of Vocational Rehabilitation White Plains Office was responsible for sending 125 disadvantaged youths to many colleges as a result of a group cooperative agreement with community-based programs servicing these groups. Twelve of the 63 students in the College Careers Program were sponsored by the Division of Vocational Rehabilitation White Plains Office.

While the Neighborhood Youth Corps experience is new and has not yet had sufficient time or money to demonstrate its true potential, the group has learned that:

- It is possible to take young people who have very little educational aptitude, and by intense counseling and remedial education, motivate them to carry a full schedule of college level work. (This is the principal distinguishing feature between the college career idea and other programs which "cream off" the top students.)
- Students must be given support and counseling from the Youth Corps counselors who have motivated them to try. In other words, the counselor must be prepared to act as a foster parent for as long as necessary. This may include taking long distance telephone calls and making long trips to college.
- The student must be assured the financial support he will need. In many cases this includes clothing, books, social events and transportation, in addition to tuition, board and room.
- Not only is it desirable but in most cases imperative that the youths (mostly black) be placed in colleges where the young person could improve his self-image. In an institution where, for the first time, he could see a college president, professors and teachers who were black, the average Youth Corps enrolee began to believe that his dream had a chance of becoming a reality.

THE DIVISION OF VOCATIONAL REHABILITATION AND THE LOCAL SCHOOL DISTRICT SHOULD WORK CLOSELY TO PROVIDE VOCATIONAL REHABILITATION SERVICES PRIOR TO HIGH SCHOOL TERMINATION — PREFERABLY AT THE TENTH GRADE LEVEL. PRIORITY: ESSENTIAL

This will prevent individuals from developing deep-seated vocational handicaps by providing services while educational prescriptions can still be developed in school. The New York State Employment Service should share with public education and Division of Vocational Rehabilitation the responsibility for realistic training and placement.

IN ORDER TO PREPARE DISADVANTAGED YOUTH FOR CONTINUING OR HIGHER EDUCATION, WE RECOMMEND THAT SEVERAL SMALL, CONVENIENTLY LOCATED SCHOOLS BE ESTABLISHED TO PROVIDE CONCENTRATED TRAINING IN REQUIRED EDUCATION SKILLS. PRIORITY: URGENT

The ratio of students to teachers must be very low and volunteers should be trained to do part of the job. The goal should be to prepare each student to take advantage of any further education he may desire, including college.

Among the economically disadvantaged youths there are a great many people who have dropped out of high school. We have found that about 75 percent of these youths can be motivated to acquire more education. However, when one reads at a fourth-grade level at age seventeen, his return to public school is dubious. What he needs is special, remedial, individualized education which must be provided by teachers capable of understanding his problems and recognizing his potential.

Among those disadvantaged young people who drop out of school, there are many who have no suitable place to live. In some cases, in fact, this is the reason for their dropping out. Some live in hallways; some sleep on the floor of crowded apartments with 13 other children. Some have alcoholic parents who subject them to abuse. The young people try to live in these circumstances but often find themselves back on the street. We must provide an environment in which it will be possible for young people to learn. We recommend a dormitory or "live in school," not an institution-type school, but more like a home.

Education, however, should be the primary purpose rather than the provision of a home. In a sense it would be something like a prep school with its goal to prepare young people for higher education.

IN COOPERATION WITH THE DIVISION OF VOCATIONAL REHABILITATION AND THE NEW YORK STATE EMPLOYMENT SERVICE, OCCUPATIONAL TRAINING FACILITIES SHOULD PROVIDE THE FOLLOWING SERVICES WHEN APPROPRIATE:

- OCCUPATIONAL EXPLORATION WITHIN THE RANGE OF CAPABILITIES DETERMINED BY THE DIAGNOSTIC CENTER;
- SPECIFIC SKILL TRAINING;
- GUIDANCE AND COUNSELING SERVICES;
- RELATED REMEDIAL INSTRUCTION, INSTRUCTION IN ARITHMETIC AND COMMUNICATION SKILLS;
- RE-EVALUATION OF OCCUPATIONAL GOALS;

- HEALTH AND REFERRAL SERVICES;
- JOB DEVELOPMENT;
- JOB PLACEMENT;
- FOLLOW-UP SERVICES. PRIORITY: ESSENTIAL

The occupational training facility should have referral channels to labor, industry and other institutions for further training or academic instruction.

WE RECOMMEND SUPPORTIVE SERVICES FOR MEN AND WOMEN WHO ARE ENTERING BUSINESS AND INDUSTRY FOR THE FIRST TIME AND FOR PEOPLE WHO HAVE BEEN CONSIDERED UNEMPLOYABLE EXCEPT FOR BRIEF PERIODS OF TIME, INCLUDING THOSE SERVICES WHICH WOULD:

- MAINTAIN THE DIGNITY OF THE WORKER;
- PROVIDE NEEDED HELP WITHOUT DESTROYING THE WORKER'S SELF-CONFIDENCE;
- HELP SOLVE PERSONAL PROBLEMS;
- SECURE NECESSARY TRAINING;
- SECURE NECESSARY EDUCATION;
- INSURE UPWARD MOBILITY IN TRAINING, EDUCATION AND JOB STATUS;
- INTERPRET THE WORKER TO HIS IMMEDIATE SUPERIOR;
- EDUCATE THE EMPLOYER;
- PROVIDE COUNSEL ON A REGULAR BASIS;
- CONDUCT GROUP COUNSELING SESSIONS WITH WORKERS AND EMPLOYERS. PRIORITY: URGENT

WE RECOMMEND THE DEVELOPMENT OF AN OCCUPATIONAL DIAGNOSTIC SERVICE. PRIORITY: ESSENTIAL

This might improve several physical facilities in the county and facilitate an in-depth mental, physical and vocational workup on individuals prior to training or placement in sheltered work areas. Hopefully, this would be centralized administratively and decentralized operatively. All concerned agencies should be involved in this effort. The short objective range would be to serve 500 clients a year.

THERE ARE GAPS BETWEEN THE AVAILABILITY OF MANY SERVICES AND THE PEOPLE WHO NEED THE SERVICES IN THE POVERTY GROUP. THESE GAPS EXIST BECAUSE THE LOCATIONS ARE OFTEN INACCESSIBLE DUE TO THEIR GEOGRAPHICAL LOCATION AND TRANSPORTATION DIFFICULTIES. WE RECOMMEND THE IMPLEMENTATION OF THE FOLLOWING PROPOSAL, "WHEELS FOR THE HANDICAPPED." PRIORITY: URGENT

The purpose of the proposal is to transport the handicapped from home to job, to a training center or a clinic, to employ the indigenous worker, and to develop a training center in vehicle transportation and maintenance.

Necessary staff includes a director, assistant director, dispatcher to handle traffic and rides, and a dispatcher's assistant, a secretary, social worker, supply clerk and purchasing agent and a building maintenance man.

Ten vehicles, ten drivers, extra driver trainers and a sufficient number of mechanics would complete the initial staff requirements.

Suggestions for operations are:

- A reasonable fee charged for all working handicapped using the service.
- All non-profit organizations presently using their own transportation and wishing to discontinue in favor of Wheels, must allot 80 percent of their past budget to Wheels or cost-per-ride basis for all non-paying clinical cases.
- Any family of middle-income standing will be expected to pay a predetermined weekly fee for services.
- All repairs of other non-profit organization vehicles will be billed for parts, and labor and ter percent for handling.
- It is suggested that handicapped who are on the job be served first, handicapped attending training centers in preparation for jobs, second and third, that in between work hour deliveries, (which are mostly early morning and 5:00 p.m.) clinical patients be accommodated. This last phase of service will in a short period of time exceed the capacity of the original ten vehicles and must be approached with care.
- A building should be purchased to house the vehicles and office. The building may serve as a center for job clearance for the handicapped, or a meeting place for the Coordinating Committee for the Handicapped, which would serve as a Wheels advisory board.

- Transportation of the handicapped to group social affairs may be possible.
- Emergency ambulance service may be a possibility.
- It is suggested that a home care unit be established to serve the handicapped. Many are without families and need to be fed and cared for during short periods of time. This care unit could very well be handled by indigenous workers who eventually could be trained as practical nurses.
- With a staff of 30 involved in this plan, a cafeteria becomes a possibility. This area is an excellent training situation.

It is quite conceivable that if "Wheels for the Handicapped" is established, both handicapped and indigenous workers can soon become taxpayers. In many cases, it will be the first time that some will join the labor force. There are great possibilities for making this organization self-supporting and for expanding in-service and trainee possibilities.

THERE IS A NEED FOR SENSITIVITY TRAINING FOR ALL STAFF TO CORRECT: PROFESSIONAL RIGIDITY AND BIGOTED ATTITUDES OF STAFF; LACK OF UNDERSTANDING OF THE PROBLEMS OF THE POOR; INABILITY OF STAFF TO COMMUNICATE WITH THE POOR BECAUSE OF THE ABOVE MENTIONED ATTITUDES; INDIVIDUALS WHO MISUNDERSTAND WHAT THE SERVICES ARE DESIGNED TO ACCOMPLISH AND SERVICES WHICH ARE UNKNOWN TO THE POOR. PRIORITY: ESSENTIAL

IN THE AREA OF PERSONS WHO WERE HANDICAPPED DUE TO SOCIAL ENVIRONMENT, SUCH AS LOW-INCOME FAMILIES, HARD CORE UNEMPLOYED, WELFARE RECIPIENTS, NARCOTIC ADDICTS, JUVENILE DELINQUENTS AND ALCOHOLICS, IT WAS GENERALLY FELT THAT COMMUNITY ACTION PROGRAMS SUCH AS THE NEIGHBORHOOD YOUTH CORPS, MDTA-OJT OF THE URBAN LEAGUE OF WESTCHESTER, NATIONAL ALLIANCE OF BUSINESSMEN, CAMPS COMMITTEE AND ALL OF THE OTHER AGENCIES DIRECTLY OR INDIRECTLY INVOLVED IN HUMAN BETTERMENT SHOULD COORDINATE ALL THEIR FORCES AND ASCERTAIN WHAT IS NECESSARY TO IMPROVE THE CLIMATE FOR THE CULTURALLY DEPRIVED, THE DISADVANTAGED AND THE POOR. HIGH PRIORITY

The most important problem our community is facing is how to "prevent the children of poverty from becoming the parents of poverty in the next generation."

WE RECOMMEND THE UTILIZATION OF THE AREA VOCATIONAL CENTERS DURING OFF-SCHOOL HOURS FOR TRAINING AND WORK ORIENTATION PHASE OF THE REHABILITATION PROGRAM. PRIORITY: URGENT

These area centers offer wide ranges in program possibilities and have the physical potential to provide the required broad spectrum of skill orientation. In addition to the area centers, several high schools in the county could be utilized to provide specific training services. The effective coordination of the total program would, of course, be essential.

THERE IS A NEED TO MAKE FURTHER USE OF PARAPROFESSIONALS AND TO REEXAMINE PRESENT PROFESSIONAL REQUIREMENTS. HIGH PRIORITY

There is concern that status needs for jobs mask the actual requirements to perform certain jobs. These efforts at job dilution will result in more effective utilization of manpower.*

WE RECOMMEND ADEQUATE TRAINING PROGRAMS FOR THE DEPRIVED. PRIORITY: ESSENTIAL

Especially where industries lack training programs, the office of the county coordinator of occupational education should be utilized to provide the training.

ADDITIONAL SHELTERED AND SEMI-SHELTERED WORKSHOPS SHOULD BE ESTABLISHED IN THE COUNTY. PRIORITY: URGENT

There is an urgent need for a store-front type, semi-sheltered working environment for individuals who cannot work independently. This would provide easy access to services in the neighborhood which, due to difficult transportation problems, might not otherwise be provided.

---

*See Appendix A, p.234 for practical examples of paraprofessional duties in California.

HEART, CANCER, STROKE AND OTHER MEDICAL IMPAIRMENTS

The recommendations of the Region II Heart, Cancer, Stroke and Other Medical Impairments Committee reflect the absence of services as well as the lack of information about those services which are available.

The need for utilizing preventive rehabilitation to diagnose and treat conditions early enough to obviate or minimize disability is one area of concern. Another is the need for a new definition of disability which would consider the ability or inability of an individual to adequately function in his everyday, routine activities.

The major emphasis of the recommendations is the need to educate the community about the needs in this health impairment area, including preventive health measures, medical treatment and follow-up, nutrition, homemaker services, financial dependency and welfare, independent living, and the activities of daily living.

A COMMUNITY ACTION PROGRAM FOR STROKE PATIENTS SHOULD ALSO EMPHASIZE AND ENCOURAGE THE USE OF AVAILABLE INFORMATION AND REFERRAL SERVICES BY BOTH PHYSICIANS AND THE PUBLIC IN LOCATING COMMUNITY SERVICES FOR THE STROKE PATIENT. PRIORITY: URGENT

A COMMUNITY EDUCATION PROGRAM WHICH WOULD EMPHASIZE THE THERAPEUTIC VALUE OF OCCUPATIONAL THERAPY, SPEECH THERAPY AND THE COUNSELING SERVICES SHOULD BE UNDERTAKEN, AIMED AT THE PHYSICIAN GROUP AND THE PUBLIC, AND A PROTOCOL FOR FUNDING A COMMUNITY ACTION PROGRAM TO DEMONSTRATE THE VALUE AND USE OF THESE SERVICES IN THE REHABILITATION OF STROKE PATIENTS SHOULD BE PREPARED IMMEDIATELY. PRIORITY: URGENT

A COMMUNITY EDUCATION PROGRAM TO EMPHASIZE THE IMPORTANCE AND VALUE OF NUTRITIONAL SERVICES, PARTICULARLY THE COUNSELING AND FOLLOW-UP ASPECTS, NOT ONLY FOR THE STROKE PATIENT, BUT ALSO FOR PATIENTS WITH HEART DISEASE, SHOULD BE UNDERTAKEN, AIMED AT THE PHYSICIAN AND THE PUBLIC. PRIORITY: URGENT

EVERY HOSPITAL IN THE COUNTY SHOULD HAVE AND ENCOURAGE THE USE OF CONSULTATION FROM A PSYCHIATRIST OR A PHYSICIAN WHO HAS BEEN SPECIFICALLY TRAINED IN THE CARE OF STROKE PATIENTS. PRIORITY: URGENT

HOMEMAKER AND HOUSEKEEPER SERVICES MUST BE MADE READILY AVAILABLE TO STROKE PATIENTS UTILIZING AVAILABLE RESOURCES OR CREATING NEW ONES, SUCH AS THE DISADVANTAGED WHO CAN BE TRAINED TO DO THIS. PRIORITY: ESSENTIAL

> Homemaker and housekeeper services are not readily available to stroke patients in the county primarily because the patients do not know where to obtain this service and the patients cannot afford this care.

WE RECOMMEND THAT THE COMMUNITY CONSIDER A CHRONIC CARE UNIT FACILITY, BUILT AND STAFFED TO BETTER MEET THE NEEDS OF STROKE PATIENTS. PRIORITY: DESIRABLE

> Recent surveys indicate inadequate services for this large group of patients in the community.

WE RECOMMEND THAT SERIOUS CONSIDERATION BE GIVEN TO THE DEVELOPMENT OF TRAINING INSTITUTIONS AND FACILITIES ESPECIALLY FOR HEALTH AND SUPPORTIVE PERSONNEL IN NEUROLOGICAL DISORDERS. PRIORITY: URGENT

> The shortage of manpower is a major obstacle to meeting the problems of neurological disability. This, in turn, has created economic factors. Training facilities are inadequate: recruitment competition has escalated salaries. The acuteness of the problem is aggravated by the high birth rate and the increased older age of the population where the incidence of neurological disabilities is high.

THERE IS A NEED FOR MORE TRAINED HEALTH AND SUPPORTIVE PERSONNEL FOR RESPIRATORY DISEASES SUCH AS ASTHMA AND EMPHYSEMA AND OTHER ENVIRONMENTAL DISEASES WHICH ARE INCREASING IN THE GENERAL POPULATION. PRIORITY: ESSENTIAL

The entire area of respiratory disease, for example, poses special rehabilitation problems. Hundreds of persons need rehabilitation services as victims of emphysema. These services are almost totally lacking in this area at this time. Respiratory disease is only one of the many chronic disease categories that will have to be explored as our population ages.

WE RECOMMEND THAT MORE ATTENTION BE GIVEN TO EARLY DETECTION OF DISABILITY AND PREVENTION OF DISABILITY. WE ARE PARTICULARLY AWARE OF THE NEED FOR EARLIER DETECTION OF DISABILITY, POTENTIAL DISABILITY, AND AT THIS TIME, THE PREVENTION OF DISABILITY. THE SCHOOL SYSTEMS, PUBLIC AND PRIVATE, PRESENT THE BEST OPPORTUNITY TO DETECT PHYSICAL, MENTAL, SOCIAL, CULTURAL, ECONOMIC AND EDUCATIONAL HANDICAPS. PRIORITY: URGENT

There is great evidence that in Suffolk far too many children completed all or a considerable part of their education without being detected and/or treated for serious handicaps, particularly social handicaps.

Hopefully we can provide teachers, school nurses and related school personnel with more exact information about referral services, and where necessary, heighten their sensitivity in recognizing and detecting handicapping conditions. In most communities, about one-third of the population is attending school or college. There are cases where school authorities are well aware that a child lives under the social, economic or emotional circumstances that make it totally impossible for the child to function to any effective degree as a human being or a student. Granted, school authorities may be somewhat limited in certain actions they can take in these situations, but they are not limited in making referrals and re-referrals to one or more agencies that might help, and for persisting until the problem is on the way to resolution.

In addition to the schools, other agencies and individuals could serve as early detection and referral points; job centers, neighborhood action centers, social and health workers. Just as we should heighten the interests of school personnel in detecting disability early, we should try to do the same sensitizing for all personnel who are in a position to detect mental, physical and social disabilities early.

We can do far more for all our socially and economically handicapped. In regard to handicapped children, we must find better procedures for identification and resolution of problems, and we can start by trying to improve knowledge, attitudes and behavior of adults in positions of authority and rehabilitative responsibility about their responsibility to help develop solutions to problems of the handicapped. In certain areas, problems of the disadvantaged black handicapped child may often be given limited attention, and sometimes with inadequate follow-up.

In addition to school children not having significant disability detected or resolved, a significant number of public employees have disability undetected and untreated. We are stressing the fact that today, as never before, large segments of our population are in school or work situations where it is relatively easy to communicate with them about rehabilitation, detection and treatment services and to begin the rehabilitation process. There is a need to increase awareness and knowledge of those in positions to detect handicaps. Responsibility for detection must be given or else it will always be someone else's job. Most people won't get involved unless it is "their job."

WE RECOMMEND THAT IN THE DEVELOPMENT OF SUMMARIES OF THE NUMBER OF DISABLED, SOME SIMPLE RULE BE USED, SUCH AS, IS THE INDIVIDUAL OR GROUP ABLE OR UNABLE TO CARRY OUT NORMAL EXPECTED ROUTINE ACTIVITIES IN RELATION TO SUCH ACTIVITY AREAS AS PRE-SCHOOL, SCHOOL, EMPLOYMENT, DAILY LIVING, HUMAN RELATIONSHIPS AND RETIREMENT? PRIORITY: URGENT

A new definition for disability for estimating the number of disabled is essential. Exact definitions of disability are often hard to agree upon. There are judicial and administrative definitions relating to benefits and compensation claims. There are medical definitions. Often disability is equated with a given handicap. At times, a client's opinion of the degree of his disability conflicts with the evaluator's opinion. In most instances, an enumeration of handicapping conditions by disease entity category serves only a limited purpose for rehabilitation planning.

MORE RESEARCH AND EXPERIMENTATION IS NEEDED IN ORDER TO DEVELOP MORE EFFECTIVE SOCIAL, CULTURAL AND RECREATIONAL PROGRAM OPPORTUNITIES FOR HANDICAPPED INDIVIDUALS. PRIORITY: ESSENTIAL

There has to be greater recognition of the value of such activities in terms of their therapeutic value and overall contribution to the well-being of a person whether he is handicapped or not and regardless of age. In our counties there are no arrangements made to involve the handicapped in the social, recreational and cultural activities except for isolated instances.

There is also a need for more coordination of effort on the part of private and public agencies to organize the use of and involvement in existing community programs by handicapped individuals. Duplication of efforts or fragmentation of such services should be avoided. A county central information exchange center could be responsible for directing this community organization task.

WE RECOMMEND THAT A VERY HIGH PRIORITY BE GIVEN TO INITIATING DISCUSSION ON HOW WE MIGHT REMEDY THE SITUATION THAT NOW EXISTS ON THE COMPLETE LACK OF RESIDENTIAL FACILITIES NEAR REHABILITATION FACILITIES AND PLACES OF WORK FOR THE HANDICAPPED. PRIORITY: URGENT

Acknowledging the difficult problems in transportation, we are concerned that more clients are unable to use existing services due to the lack of residential facilities.

BECAUSE MANY TIMES THE HOME ENVIRONMENTS OF THE SEVERELY DISABLED ARE INADEQUATE TO MAINTAIN THE GAINS THEY HAVE MADE IN REHABILITATION PROGRAMS AND REGRESSION OCCURS, IT IS RECOMMENDED:

- THAT COUNTY AGENCIES, GOVERNMENT OR VOLUNTARY, BE ENCOURAGED TO ESTABLISH AND STAFF HALF-WAY HOUSES FOR THE DISABLED RETURNING TO COMMUNITY LIVING, THE HALF-WAY HOUSE SERVE THE BROAD SPECTRUM OF AGE AND DISABILITY, AND IF NECESSARY, SERVE AS A LONG-TERM PROTECTIVE HOME ENVIRONMENT;
- THAT GRANTS BE MADE AVAILABLE FOR THE ESTABLISHMENT AND MAINTENANCE OF HALF-WAY HOUSES BY VOLUNTARY, PRIVATE OR PUBLIC AGENCIES. PRIORITY: ESSENTIAL

MENTAL HANDICAPS

Some of the world's largest mental hospitals are in Region II. Pilgrim, Central Islip and Kings Park State Hospital are situated in Suffolk County as is the Veteran's Administration Hospital at Northport. In addition, Suffolk State Hospital has been established at Central Islip, and the Rockland State Hospital, where the first rehabilitation program was introduced in New York State about ten years ago, is located in Rockland County. The total patient capacity of the mental hospitals is approximately 40,000.*

The Mental Handicaps and Addictions Task Force sees as an urgent priority, the extension of rehabilitation services in and out of the mental hospitals, and the initiation of mobile services for community use.

The committee also examined the spread of drug addiction, one of the most distressing behavioral developments of this decade, and feels that treatment centers in store fronts or facilities in poverty areas are essential in at least beginning to cope with this problem at the community level. Although there was some committee discussion regarding legalization of drugs, no recommendations were submitted.

Still another area of concern is the unidentified population of non-patients who are mentally ill. A major indicator for the identification and treatment of the non-patient is a study of psychiatric rejectees in World War II. At that time the military service rejected almost one million men for psychiatric reasons. The majority of these men had no prior history of hospitalization nor did they present any evidence of major pathology. Geographically, many of the men came from the agricultural South. Significantly, in 1968, 27 years later, there is still a large, unidentified population of the mentally ill.

The development of Community Mental Health Centers in New York State demonstrates the concept of accepting new areas of service, the participation of community groups including consumers and/or their surrogates, and outreach to serve those who need treatment in their own communities. The broad range of meaningful possibilities for mental health including treatment for children and adolescents through these centers is just being tapped.

A difficult, unmet problem recognized by the Mental Handicaps Committee is the provision of half-way houses, foster home care and other residential accommodations in the community. This problem will become exacerbated with the expanding population and the estimate that mental illness afflicts at least ten percent of the population.

The Region II Mental Handicaps and Addictions Task Force has surveyed mental illness in Nassau, Suffolk, Rockland and Westchester Counties. The inadequacies and insufficiencies of existing treatment, rehabilitation services and housing for the mentally handicapped are reflected in the following recommendations.

---

*See Tables on p. 191 for information on patients in Region II mental hospitals.

THE SPECIFIC DESIGN OF PROGRAMS MUST TAKE INTO ACCOUNT THE HETEROGENEITY OF THE MENTALLY HANDICAPPED POPULATION, BOTH "PATIENT AND NON-PATIENT" GROUPS. HIGH PRIORITY

Suggested programs include:

- Programs designed for the recognition, unblocking and development of the individual's assets:
  1. Individual and group psychotherapy
  2. Individual and group counseling, especially for the underprivileged and the displaced
  3. Social therapy clubs, groups and councils to assist in social and personal rehabilitation.

- Programs designed specifically for vocational rehabilitation:
  1. Therapeutic work experiences
  2. Work-oriented industrial experiences
  3. Vocational guidance and evaluation
  4. Sheltered workshops.

- Programs designed for educational rehabilitation should be reexamined and restructured.

In addition to the above, tools, techniques and procedures must be developed aimed at identifying and reaching the vast numbers of the non-patient group not being served at the present time.

THERE IS A NEED FOR MOBILE MENTAL HEALTH DIAGNOSTIC CENTERS WHICH COULD BE MADE AVAILABLE THROUGHOUT THE COUNTY. HIGH PRIORITY

Transportation problems inhibiting treatment can be effectively handled in this way.

THERE IS A NEED FOR DAY TRAINING OR DAY CARE SERVICES FOR THE SEVERELY MENTALLY ILL TO PREVENT REHOSPITALIZATION OR INITIAL HOSPITALIZATION. PRIORITY: ESSENTIAL

THERE IS A NEED FOR WALK-IN CLINICS FOR THE EX-MENTAL PATIENT WHO CAN SEEK EMERGENCY HELP WHENEVER REQUIRED WITHOUT SUBMITTING TO USUAL RED TAPE. PRIORITY: ESSENTIAL

Experience shows that brief therapy and support immediately available are more efficacious than extended traditional therapy for the mental patient.

THERE IS A NEED FOR IMPROVED AFTER-CARE SERVICES FOR THE DISCHARGED MENTAL PATIENT. PRIORITY: ESSENTIAL

MENTAL HEALTH CARE SHOULD BE PROVIDED FOR THE EMOTIONALLY DISTURBED TEENAGER OR SCHOOL DROPOUT. PRIORITY: URGENT

SMALL CENTERS TO COUNSEL DRUG ADDICTS SHOULD BE ESTABLISHED. HIGH PRIORITY

The center should be located in a store front or in two or three rooms in a facility situated in the heart of poverty areas. The staff could include: two ex-addicts, full-time for therapy; a psychiatrist on a part-time basis for consultation and diagnosis; street workers and one full-time secretary. Area hospitals would be asked to cooperate by making available beds for detoxication.

Training programs would include programs to train: 1) ex-addicts to help those who are hooked; 2) hospital staff; 3) prospective employers; and 4) a program to reeducate parents (especially mothers) of addicts and ex-addicts.

THE DIVISION OF VOCATIONAL REHABILITATION SHOULD CONTINUE TO BE EFFECTIVELY INVOLVED AND EXPAND ITS INVOLVEMENT IN THE SERVICES OF THE MENTAL HOSPITAL AND COMMUNITY MENTAL HEALTH CENTERS. HIGH PRIORITY

There is a need for greater rehabilitation emphasis in state mental hospitals. This could be implemented by establishing work evaluation or prevocational programs in the hospital.

THERE IS A NEED FOR VOCATIONAL REHABILITATION OF THE FORMER MENTAL PATIENT AND THE EMOTIONALLY DISTURBED IN THE COMMUNITY. PRIORITY: ESSENTIAL

Often after release, treatment is interrupted by inaccessible facilities.

COMMUNITY HEALTH BOARDS SHOULD RECOGNIZE AND EMPHASIZE REHABILITATION BY ADDING REPRESENTATIVES OF THIS AREA TO GOVERNING BOARD AND ADVISORY COMMITTEE MEMBERSHIPS. HIGH PRIORITY

This will facilitate communication, information, and hopefully, services.

THERE IS A NEED FOR A WORK-STUDY PROGRAM FOR EMOTIONALLY DISTURBED YOUNGSTERS IN PUBLIC SCHOOLS SIMILAR TO THE PROGRAM FOR THE MENTALLY RETARDED. HIGH PRIORITY

This important service will enhance rehabilitation progress for this large group.

THERE IS A NEED FOR MORE HOUSING FACILITIES, FOSTER HOMES AND HALF-WAY HOUSES FOR THE MENTALLY ILL. HIGH PRIORITY

THERE IS A NEED FOR THE ESTABLISHMENT OF A RESIDENCE IN THE COMMUNITY FOR DISCHARGED MENTAL HOSPITAL PATIENTS WHO CAN BE HOUSED ON AN INTERIM BASIS. PRIORITY: URGENT

Many mental hospital patients are not discharged because there is a lack of adequate housing facilities for them in the community.

SOCIAL-RECREATIONAL ACTIVITIES AND PROGRAMS, ESPECIALLY IN THE EVENINGS AND WEEKENDS, ARE SORELY NEEDED FOR THE MENTALLY ILL INDIVIDUAL. NO SUCH PROGRAMS EXIST IN THE COMMUNITY. PRIORITY: ESSENTIAL

Rather than being non-essential, this very important aspect of recovery and relationships to normal community surroundings is critical for this group.

MENTAL RETARDATION

Region II is the site of two of the largest state facilities for care of the mentally retarded: Letchworth Village in Thiells, Rockland County and Suffolk State School in Selden, Suffolk County. The latter institution, which has a large severely retarded population, is being urged to extend the use of its facilities to the community for rehabilitation purposes.

The New York State Department of Mental Hygiene, Mental Retardation Division, has just purchased two houses in Spring Valley, Rockland County, as community residences for mental retardates able to live and work in the community. This inaugurates a new service area in the rehabilitation of mental retardates.

The Nassau County Association for the Help of Retarded Children, one of the most comprehensive and innovative facilities in this region and perhaps in New York State, has a life continuum program including the following: diagnostic services including medical and psychiatric, psychological, and social services; information and referral services; preschool, day care and occupational day care programs; a full-time school with accredited teachers; a workshop for 225 retardates, approximately 25 percent of whom were placed in industry after training. The vocational training center and workshop provides prevocational training and personal adjustment training, as well as vocational training in packaging, machine work, shipping and receiving, material handling, assembly, maintenance, cafeteria, child care, greenhouse, office practices, boutique shop and recreation. The facility also has a transportation system. An exciting future prospect of the Nassau Association for Help of Retarded Children is the construction of another workshop in Freeport.

RESIDENT PATIENTS AND ADMISSION RATES IN STATE MENTAL HOSPITALS BY COUNTY OF RESIDENCE
(FISCAL YEAR ENDED MARCH 31, 1966)

County of Residence	Number of Admissions 1966	Admission Rate Per 100,000 population	Resident Patients as of 3/31/66	Resident Rate Per 100,000 population
Nassau	1,443	101.3	2,221	155.9
Rockland	379	223.9	429	253.4
Suffolk	1.908	214.9	1,995	224.7
Westchester	1,134	131.1	2,816	325.7

OUTPATIENT CLINIC TERMINATIONS BY COUNTY OF RESIDENCE AND AGE UPON ADMISSION
APRIL, 1966 TO MARCH 31, 1966

County of Residence	Number of Terminations	Percent Distribution by Age on Admission (Years)							
		<10	10-14	15-19	20-24	25-44	45-64	>65	Unk.
Nassau	4,917	12.1	16.7	16.7	5.8	34.2	10.4	1.7	2.4
Rockland	558	25.6	15.8	10.7	8.6	33.0	5.6	0.4	0.3
Suffolk	2,916	18.7	16.1	14.7	7.2	35.2	5.9	0.7	1.5
Westchester	4,223	13.7	14.5	14.5	8.7	35.1	11.9	0.8	0.8

RELEASES AND RETURNS TO STATE MENTAL HOSPITALS, BY COUNTY OF RESIDENCE
APRIL 1, 1965 TO MARCH 31, 1966

	Releases From Institutions					Returns To Institutions			
		Civil State Hospitals							
County of Residence	Total Releases	Direct Discharges	Other Releases	State Hosps. for the Criminally Insane	Licensed Hospitals	Total Returns	Civil State Hospitals	Licensed Hospitals	Total Deaths
Nassau	2,210	471	953	25	771	384	365	19	380
Rockland	510	251	185	2	72	78	73	5	55
Suffolk	2,205	939	948	12	306	349	346	3	291
Westchester	2,217	352	901	24	940	541	450	91	338

Source: New York State Statistical Yearbook, 1967, New York
State Division of the Budget, Albany, New York

The Westchester County Association for the Help of Retarded Children has a workshop facility which is being reevaluated at the present time.

The Suffolk County Association for the Help of Retarded Children operates a vocational training center, a preschool program for retardates, a day care program, and provides evaluation and diagnostic service for approximately 214 clients.

Prevalence and incidence of the mentally retarded in Region II is indicated on the following tables. The total of those enrolled in Educable and Trainable Classes, and Resident Patients in the four counties is 9,163.

REGION II PUBLIC SCHOOL ADMINISTRATIVE UNITS PROVIDING SPECIAL CLASSES FOR CHILDREN WITH RETARDED MENTAL DEVELOPMENT

County	Educable		Trainable	
	Classes	Enrollment	Classes	Enrollment
Nassau	149	1713	67	712
Rockland	23	290	6	80
Suffolk	146	1787	39	408
Westchester	95	1278	30	331
TOTAL	413	5068	142	1531

TOTAL CLASSES 555

TOTAL ENROLLMENT 6599

Source: The University of the State of New York, The State Education Department, Bureau for Mentally Handicapped Children's Report, 1966-67

RESIDENT PATIENTS IN SCHOOLS FOR THE MENTALLY RETARDED BY COUNTY OF RESIDENCE

County	Resident Patients as of 3/31/66
Nassau	966
Rockland	152
Suffolk	508
Westchester	938
TOTAL	2564

Source: New York State Statistical Yearbook- 1967, New York State Division of the Budget, Albany, New York

Education and training for this group has been advanced by new legislation providing state funds for handicapped individuals. Section 4407 of the Education Law reads in part:

> Special provisions relating to instruction of certain (physically or mentally) handicapped children. When it shall appear to the satisfaction of the department that a (physically or mentally) handicapped child, who, in the judgment of the department can reasonably be expected to benefit from instruction, is not receiving such instruction because there are no adequate public facilities for instruction of such a child within the state because of the unusual type of handicap or combination of handicaps, the department is authorized to contract with an educational facility located within or without the state, which in the judgment of the department, can meet the needs of such child, for instruction of such child in such educational facility, and the department is further authorized to expend for such purpose a sum not to exceed two thousand dollars per annum for each such pupil.
>
> The State Education Department shall maintain a register of such educational facilities, which after inspection, it seems qualified to meet the needs of such child for instruction of such child in such educational facility. Such inspection shall also determine the eligibility of such educational facility to receive the funds hereinbefore specified.

Continuing unmet needs remain, however, and the committee therefore recommends new legislation for guaranteed income, financial subsidy, guaranteed wage, compulsory employment, increased Medicaid, and transportation supplements.

Other concerns expressed are duplication and gaps in planning, the education of the community regarding mental retardation programs and resources, and the development of personnel in paraprofessional and professional areas as well as preschool services in the normal school setting.

The recommendations of the committee are unique, sensitive, probing, and indeed pass the baton to those who are exquisitely courageous enough to ask, "why not?"

SUBSIDIES TO INDIVIDUALS ARE RECOMMENDED FOR THE MARGINALLY RETARDED, THE SEVERELY RETARDED AND THE PROFOUNDLY RETARDED:

- WE RECOMMEND THAT A GUARANTEED INCOME BE GIVEN TO THE MARGINALLY RETARDED WORKER OF NOT LESS THAN THE MINIMUM WAGE, IF HE IS SINGLE; THAT THIS INCOME BE INCREASED IN PROPORTION TO THE SIZE OF THE FAMILY; AND THAT THE GUARANTEED INCOME TABLE BE RELEVANT TO THE COST OF LIVING INDEX IN THE AREA IN WHICH HE LIVES. PRIORITY: URGENT

  For example, if it is established that the minimum cost of living for a family of four in the metropolitan area is $7,000 per year, then this retarded worker should be guaranteed the difference between his pay check and that living cost.

  Since the mildly retarded are generally employed at unskilled jobs in the private sector, their earning capacity is usually limited to the minimum wage. At present, the minimum wage is $1.60 under the provisions of the Interstate Commerce Law, and so we may assume their maximum earning capacity is generally about $3,000 per year before taxes. This minimum wage is not related to whether the employee is married, has a family, lives at home, or must maintain a separate residence. It should be obvious that a lifetime maximum income of $3,000 before taxes insures the fact that the mentally retarded at best can be expected to live in substandard conditions for his whole life.

- WE RECOMMEND THAT THE SEVERELY RETARDED WHO IS GENERALLY A SHELTERED WORKSHOP EMPLOYEE BE GIVEN A GUARANTEED INCOME OF NOT LESS THAN THE MINIMUM WAGE IN EFFECT WHERE HE LIVES. PRIORITY: URGENT

  For example, if his present earning capacity is $500 per year, he shall receive from the government $2,500 per year to bring his income up to the present $1.60 per hour. Also, since most of this population do not marry, the guaranteed family income is not likely to be applicable in the case of these workers. However, if they are married, then the family income should apply to them as it applies to the marginally retarded. This wage differential can be paid directly to the person as part of a program of guaranteed income or as an employment subsidy paid through the sheltered workshop where the client is employed.

- WE RECOMMEND THAT THE MINIMUM INCOME OF $3,000 BE PAID TO THE PROFOUNDLY RETARDED UNDER THE PROVISIONS OF THE AID TO THE TOTALLY DISABLED OF THE SOCIAL SECURITY ACT. WITHIN THIS FRAME OF REFERENCE WE ALSO RECOMMEND THAT THE AID TO THE TOTALLY DISABLED PROGRAM BE REMOVED FROM THE WELFARE OR SOCIAL SERVICE DEPARTMENTS, AND THAT THE BENEFITS BE PAID DIRECTLY TO THE CLIENT BY THE SOCIAL SECURITY ADMINISTRATION IN THE SAME WAY THAT RETIREMENT AND SURVIVOR BENEFITS ARE PAID. PRIORITY: URGENT

The profoundly retarded segment of the retarded are not usually found in sheltered workshops. They also require the basic elements of food, clothing and shelter, as well as special occupational and social services to meet their needs.

It has always seemed to us that once the condition of severe retardation has been established and it is known that this condition is incurable, it is an absurdity to use social casework procedures to process these cases.

IT IS RECOMMENDED THAT A PER CAPITA SUBSIDY SHOULD BE GUARANTEED TO EVERY AGENCY OPERATING A VOCATIONAL TRAINING CENTER AND SHELTERED WORKSHOP FOR THE SEVERELY MENTALLY RETARDED. PRIORITY: URGENT

It is recognized that the severely mentally retarded cannot produce at a rate which will absorb the overhead cost of maintaining a sheltered workshop. The difference between the production rate and the actual cost of production must therefore be subsidized by the voluntary organization which maintains the workshop. In addition to the deficit created by low production, there is the cost of ancillary rehabilitation services necessary to this type of facility, but not characteristic of a factory. No private group can afford to absorb the total number of mentally retarded who need sheltered employment without government assistance to close the financial gap created by low production and rehabilitation service.

WE RECOMMEND THAT THE WORKER'S INCOME BE SUPPLEMENTED WITH A TRANSPORTATION ALLOWANCE UP TO 90 PERCENT OF THE COST, AND ALSO THAT A TRANSPORTATION ALLOWANCE BE GIVEN TO SOCIALLY DISADVANTAGED PEOPLE WHO ARE ALSO PLAGUED WITH THIS PROBLEM WHEN JOBS ARE AVAILABLE ONLY IN PARKS AWAY FROM TRANSPORTATION CENTERS. PRIORITY: HIGH

With respect to the employment of the mentally retarded, job availability may be equated with job accessibility. If a retarded worker is earning a minimum wage and lives in an area where public transportation is available to his place of employment, then he should be expected to provide transportation out of his own income. However, if the place of employment is located in an industrial park beyond the reach of public conveyances, a transportation allowance should be granted.

WE RECOMMEND THAT A LAW BE ENACTED TO MANDATE INDUSTRY TO HIRE FIVE PERCENT OF ITS WORK FORCE FROM THE HANDICAPPED AND DISADVANTAGED POPULATIONS, WITH THE SINGLE EXCEPTION THAT WHERE INDUSTRY DOES NOT MEET THIS REQUIREMENT, THEY BE MANDATED TO CONTRACT FIVE PERCENT OF THEIR PRODUCTION TO SHELTERED WORKSHOPS EMPLOYING THE HANDICAPPED. PRIORITY: ESSENTIAL

IT IS RECOMMENDED THAT MEDICAID BE GIVEN TO ALL MENTALLY RETARDED OVER AND ABOVE GUARANTEED INCOME, AND THAT MEDICAID PROVISIONS BE LIBERALIZED TO INCLUDE REHABILITATION SERVICES SUCH AS PLASTIC SURGERY, ORTHODONTAL WORK, SPEECH THERAPY AND OTHER THERAPIES. PRIORITY: DESIRABLE

WE RECOMMEND THE DEVELOPMENT OF NON-PROFESSIONAL AND PROFESSIONAL TRAINING PROGRAMS INCLUDING:

- A COURSE FOR TEACHER-AIDE TRAINING IN WORKING WITH RETARDED CHILDREN WITH FIELD PLACEMENTS MADE WITHIN THE NETWORK OF AGENCIES SERVICING THE RETARDED;
- THE ESTABLISHMENT OF MORE TEACHER-MOM PROGRAMS;
- TO INCLUDE AS A PART OF NEIGHBORHOOD WORKERS PROGRAM, IN THE DEPRIVED OR POVERTY AREAS, UNCOVERING PRESCHOOL CHILDREN WHO MIGHT BE RETARDED AND WHO ARE NOT BEING SERVED;
- IN-SERVICE TRAINING PROGRAMS FOR TEACHERS;
- TRAINING OF RETARDED ADULTS TO WORK AS TEACHER-AIDES;
- TRAINING OF SUPERVISORS (FOREMEN) WORKING IN SHELTERED WORKSHOPS TO DEAL WITH UNACCEPTABLE SOCIAL BEHAVIOR IN A THERAPEUTIC MANNER;
- TRAINING OF AIDES TO TEACH RETARDATES TECHNIQUES OF MASTERING PROBLEMS OF COMMUNITY LIVING, E.G., TRAVELING TO WORK. PRIORITY: ESSENTIAL

FOR PRESCHOOLERS, DAY CARE AND HEAD START PROGRAMS SHOULD INCLUDE SOME RETARDED CHILDREN WHO CAN PARTICIPATE IN A NORMAL SETTING WITHIN AN AGE GROUP APPROPRIATE TO THEIR FUNCTIONING. PRIORITY: URGENT

At the same time, there should be a community education program by the agencies involved describing the advantages of a preschool experience for retarded children.

WE RECOMMEND THE EXPANSION AND CENTRALIZATION OF EXISTING REHABILITATION ADULT SERVICES FOR THE MENTALLY RETARDED TO PROVIDE COMPREHENSIVE CARE, INCLUDING:

- SHELTERED EMPLOYMENT--PAID WORK, TRAINING, AND EVALUATION OF SKILLS AND TALENTS;
- RECREATIONAL FACILITIES--PHYSICAL EDUCATION, INCLUDING SWIMMING AND SOCIAL FUNCTIONS ON EVENINGS AND WEEKENDS;
- DAY TRAINING PROGRAMS--SELF CARE, HOMEMAKING AND HANDICRAFTS;
- WORK-STUDY PROGRAMS--EVALUATION, TRAINING AND EDUCATION. HIGH PRIORITY

THERE IS A NEED TO PROVIDE A NETWORK OF AGENCIES TO COORDINATE THE SERVICES GIVEN TO THE MENTALLY RETARDED AND TO THOSE WITH MENTAL HEALTH PROBLEMS IN ORDER TO MEET THE TOTAL SOCIAL, EDUCATIONAL AND CLINICAL NEEDS OF THE RETARDED. HIGH PRIORITY

A COUNTY WIDE MENTAL RETARDATION INFORMATION AND RESOURCE CENTER SHOULD BE ENCOURAGED. HIGH PRIORITY

This agency would be responsible for the dissemination of information on Mental Retardation Programs. It would stimulate research. It would advise on grants available and assist in writing up proposals for grants.

WE RECOMMEND THAT THE FEDERAL FORMULAS BE CHANGED TO PROVIDE AT LEAST 60 PERCENT OF THE CONSTRUCTION COSTS, THE STATE OF NEW YORK PROVIDE 30 PERCENT, AND THE VOLUNTARY AGENCY 10 PERCENT. IN ADDITION, THERE SHOULD BE A PROVISION WHICH ALLOWS THE VOLUNTARY AGENCY TO BORROW MORTGAGE FUNDS FROM THE STATE AT LOW INTEREST RATES. IN NEW YORK, THIS CAN BE DONE THROUGH THE HOUSING FINANCE CORPORATION AND/OR THE MENTAL HYGIENE FACILITIES IMPROVEMENT FUND. PRIORITY: URGENT

In 1956 the State of New York passed legislation permitting the admission of trainable retarded into the public schools. As a consequence of this act, a considerable segment of the mentally retarded have been in public education facilities for a number of years and are approaching graduation. These young adults are for the most part incapable of employment in the private sector, so it may be reasoned that they must look to vocational training centers and sheltered workshops in the community or face a vacuum which would otherwise be filled by a state institution. When we add the trainable population to approximately 50 percent of the educable population who need vocational training centers and sheltered workshops, it becomes immediately apparent that such facilities must be maintained in communities throughout the state. At the present time, the Association for Help for Retarded Children is the major resource for this service, but it is unrealistic to assume that this or any other private resource can continue to expand to the degree that is necessary. At the present time construction grants are made under the Hill-Harris provision through Mental Hygiene (88-164), or PL 89-333 under Vocational Rehabilitation. Both of these federal formulas place the burden of the cost on the voluntary agency, and since the private agency already is saddled with finding sufficient funds to underwrite ongoing costs of service, they simply cannot raise the additional monies necessary to meet the cost of new facilities.

WE RECOMMEND THAT THE SAME PROVISIONS FOR CONSTRUCTION OF VOCATIONAL TRAINING CENTERS AND SHELTERED WORKSHOPS BE APPLICABLE TO OCCUPATIONAL DAY CENTERS, WITHIN THE FRAMEWORK OF VOCATIONAL REHABILITATION. PRIORITY: ESSENTIAL

We make this specific note for the reason that although Mental Hygiene Provision 88-164 does permit construction grants for this purpose, such construction would not be currently eligible under PL 89-333 (Vocational Rehabilitation).

FINDINGS AND RECOMMENDATIONS: FACILITIES AND WORKSHOPS

When discussing facilities and workshops, it must be recognized that productive work in competitive industry may not be possible for some disabled. There is need, therefore, for a facility for those who will never be able to compete in the labor market. The inadequacy of existing legislation for construction of such facilities has been considered and suggestions are given for providing a more workable formula.

Also, to avoid imposing structures and services upon a community which may bear no relation to actual needs in terms of services and their geographic location, the communities, including consumers of service, want to be involved in decision making in planning facilities and workshops. An obvious extension of this concept is that workshops and facilities need to update machinery and equipment to more relevantly reflect the needs of industry.

As described previously, the first rehabilitation program was set up in New York State in 1957 by the Division of Vocational Rehabilitation at Rockland State Hospital. Although the utilization of the existing mental hospital industries as a vehicle for prevocational training and personal adjustment training was not in the original design of this program, the creativity and ingenuity of the rehabilitation counselor lead to a new approach: in-patient rehabilitation facilities at mental hospitals. For the first time, the capability of preparing patients while still in mental hospitals for return to productivity upon release was recognized and developed. Ten years later this idea had led to the development of large scale rehabilitation on-site facilities under the Department of Mental Hygiene at Central Islip, Middletown and Creedmoor State Hospitals to provide preparation, evaluation and training to the largest group of handicapped, the mentally ill.

Even though Rockland has the Rockland State Hospital Rehabilitation Program in Region II, Rockland County and Suffolk County have very limited resources for the disabled. There is a need for comprehensive facilities and for specialized workshops.

The findings and recommendations of Region II reflecting facility and workshop needs follow:

WE RECOMMEND THAT THE FEASIBILITY OF AN EXPERIMENTAL HOMEBOUND AND LONG-TERM WORKSHOP PROGRAM BE STUDIED FOR A PILOT GROUP OF CLIENTS WITH PROVISIONS FOR STUDYING ALTERNATIVE PROGRAMS TO MEET THEIR NEEDS. GEOGRAPHIC DISTRIBUTION AND ACCESSIBILITY SHOULD BE AMONG THE CRITERIA ESTABLISHED. HUMAN AS WELL AS FINANCIAL RESOURCES WITHIN COUNTIES SHOULD BE UTILIZED IN THE DEVELOPMENT OF WORKSHOP PROGRAMS. HIGH PRIORITY

> There is some support for the impression that within the next few years there will be a switch away from the value of work, particularly for those who with even the finest of vocational services would not be in a position to absorb the newly created technologies. Apart from financial consideration which could be dealt with by changes in the tax law, a new focus would have to be found around other kinds of activities, especially service activities, perhaps largely on a non-salaried basis. Rehabilitation agencies should be called upon to provide new kinds of activities which would be remote from the world of work as we know it today.
>
> We are aware of expressions of interest in a long-term workshop to be located in Westchester and Rockland. There is virtually nothing along these lines in either county. It would prove an awesome task to implement such a program without incurring a significant financial deficit. Only where both the state and federal governments have provided fairly large sums of money have workshops managed to keep their heads above water. Perhaps long-term workshops can become the nuclei of a multi-purpose setting where productive work is not the chief focus.

WE RECOMMEND THE ESTABLISHMENT IN ROCKLAND COUNTY OF A FACILITY FOR CHILDREN AND YOUNG ADULTS WITH SEVERE PHYSICALLY HANDICAPPING CONDITIONS WHO HAVE REACHED A PLATEAU BEYOND WHICH FURTHER ACTIVE REHABILITATION CARE WILL BE RELATIVELY INEFFECTIVE AND FOR WHOM CARE AT HOME IS EITHER IMPOSSIBLE OR IMPRACTICAL.
PRIORITY: DESIRABLE

> Although the basic problem is custodial, facilities provided should include medical and orthopedic supervision, maintenance therapy (both physical and speech), schooling where indicated, and a recreational program which would include occupational therapy. The obvious locale for setting up such a facility would be as a part of or as an annex to the New York State Rehabilitation Hospital, where the above listed services are already available. Tax support would, of course, be essential. It would obviously be necessary to set up criteria for admission but I.Q. requirements should not initially be too rigid. Younger cerebral palsy children in particular should be given a sympathetic trial, after which they could be transferred to an institution such as Letchworth if it is felt that this is where they belong.

THERE IS A VITAL NEED FOR EXTENDED EMPLOYMENT OPPORTUNITIES AND SHELTERED WORKSHOP FACILITIES, ONE IN WESTCHESTER AND ONE IN NASSAU-SUFFOLK COUNTIES. PRIORITY: ESSENTIAL

The need is for a central workshop facility where long-term training and employment opportunities can be made available to handicapped people who cannot immediately enter the competitive labor market, or who will never be able to compete in the labor market. Specifically, the need is great in terms of the blind and visually handicapped, as well as the deaf and hard of hearing, and those with a combination of these severe disabilities. Ideally, such a workshop facility should be located centrally in Westchester County in or around the White Plains area where transportation facilities are most available. Hicksville seems the area most central to the bulk of the Nassau-Suffolk population. The goals of the facility are not to be production but only work conditioning and job hardening. A work activity center is more needed at present in Nassau-Suffolk. Also, the need for a center will arise in Westchester County when a general workshop is established.

WE RECOMMEND THAT THE FEDERAL FORMULA WHICH PROVIDES CONSTRUCTION FUNDS TO BUILD VOCATIONAL TRAINING CENTERS AND SHELTERED WORKSHOPS, BE REVISED SO THAT THE FEDERAL SHARE WILL BE AT LEAST 60 PERCENT, THE STATE SHARE 30 PERCENT, AND THE VOLUNTARY AGENCY SHARE 10 PERCENT. IN ADDITION, THERE SHOULD BE A PROVISION WHICH ALLOWS THE VOLUNTARY AGENCY TO BORROW MORTGAGE FUNDS FROM THE STATE AT LOW INTEREST RATES. IN NEW YORK THIS CAN BE DONE THROUGH THE HOUSING FINANCE CORPORATION AND/OR THE MENTAL HYGIENE FACILITIES IMPROVEMENT FUND. PRIORITY: URGENT

(See "Mental Retardation" p.195)

WE RECOMMEND THAT THE SAME PROVISIONS FOR CONSTRUCTION OF VOCATIONAL TRAINING CENTERS AND SHELTERED WORKSHOPS BE APPLICABLE TO OCCUPATIONAL DAY CENTERS, WITHIN THE FRAMEWORK OF VOCATIONAL REHABILITATION. PRIORITY: URGENT

(See "Mental Retardation" p.195)

THERE IS A NEED FOR MULTI-SERVICE CENTERS, AND IN ADDITION, NASSAU-SUFFOLK NEEDS A REGIONAL REHABILITATION FACILITY CAPABLE OF HANDLING UNUSUAL OR DIFFICULT CASES THAT COULD NOT BE HANDLED IN ANY OTHER FACILITY. PRIORITY: ESSENTIAL

There are many special rehabilitation problems that the committee did not have time to explore fully. There is the difficult area of correctional rehabilitation, probation, parole, narcotics. There are also the areas of alcoholism, smoking, dental problems and those multiply handicapped by alcohol and drugs.

A REPRESENTATIVE GROUP, INCLUDING CONSUMERS, MUST BE INVOLVED IN POLICYMAKING AND DISCUSSING OBJECTIVES, ALTERNATE PLANS AND PRIORITIES THAT MUST BE SET IN CONSIDERING COORDINATION OR EXISTING SERVICES, AND CREATION OF NEW SERVICES AND SERVICE AREAS. PRIORITY: URGENT

More facilities, money and more well-trained personnel are needed if the rehabilitation needs of Suffolk are to be met. There is an inadequate number of physical medicine specialists, social service personnel, physical therapists and rehabilitation counselors available in Suffolk. In addition, Suffolk at present does not have sufficient and suitable sheltered workshops facilities, special educational facilities. The absence of resident facilities for the handicapped while in training facilities is a particularly serious problem.

Many of the major elements of rehabilitation services and facilities in Suffolk are provided by quite independent groups. These groups have the prerogative, based on the realities of their budget, sense of mission, geographic location or legislative mandate, of determining what services will be offered, the physical location of services, and to a degree -- how many and who will be served.

Very often major decisions relating to rehabilitation in Suffolk are made outside the county without involving many, or at times, any Suffolk resident with responsibility and an active interest in rehabilitation.

THERE IS A NEED FOR GREATER REHABILITATION EMPHASIS IN STATE MENTAL HOSPITALS IMPLEMENTED BY ESTABLISHING WORK EVALUATION OR PREVOCATIONAL PROGRAMS IN THE HOSPITAL. PRIORITY: URGENT

WE RECOMMEND THAT THE COMMUNITY CONSIDER A CHRONIC CARE UNIT FACILITY, BUILT AND STAFFED TO BETTER MEET THE NEEDS OF STROKE PATIENTS. PRIORITY: URGENT

Rehabilitation services should be a major emphasis in such a setting.

A HALF-WAY HOUSE LOCATED IN RELATION TO EXISTING FACILITIES AND WORKSHOPS IS NEEDED TO PROVIDE SOCIAL CONDITIONING AND TRAINING IN INDEPENDENT LIVING FOR EMOTIONALLY DISTURBED, MENTALLY CONVALESCENT AND OTHER MULTIPLY HANDICAPPED DEAF OR BLIND PERSONS WHO ARE CAPABLE OF SUCH PROGRESS. PRIORITY: DESIRABLE

This same facility could serve as the logical resource for those who are not so capable yet who do not need or desire institutionalization.

FINDINGS AND RECOMMENDATIONS: ADMINISTRATIVE CONSIDERATIONS

Foremost among recognized problems are the administration of state rehabilitation and the administration of local rehabilitation.

The former finds affirmation in the creation of a Department of Rehabilitation or a Human Resources Agency as a suggested remedy to coordinate far-flung and unrelated existing rehabilitation services. The establishment of a County Rehabilitation Coordinator and County Rehabilitation Council is seen as a local adaptation to facilitate delivery of services. An ongoing permanent planning structure is also recommended.

Uniform standards for eligibility, training and also for geographical planning districts is urged. Consumers of services must be participants at the policy making and decision making levels.

The coordination of services and planning is seen as a prime objective in the delivery of health, medical, rehabilitation, education and other community services to eliminate serious gaps in service and to promote full utilization of existing public and private resources. The implication is also clear that the same community people are involved in more than one planning program and are weary of doing the job again and again without experiencing some implementation of proposals.

Utilizing public relations techniques and media for education and participation goals, as well as establishing a clearinghouse for information, is advocated. The lack of a public relations program is probably the single most important reason for the failure to attract and recruit rehabilitation personnel. Also, many more training opportunities and grants must be made available in the rehabilitation disciplines.

The projections of personnel shortages in health, social services, rehabilitation and education disciplines are a grim reality. The development of job analysis and job dilution methods to produce real rather than status job requirements are being applied to these professional areas, but in a way that is piecemeal and makeshift. Paraprofessionals must be trained and utilized across the board in every discipline. In Colorado, for example, an assistant doctor curriculum of five years has been developed in pediatrics. This is only a precursor of what must come in other professions. What is or is not done to meet the challenge of this manpower crisis will affect the quality of life in this country for generations.

The evaluation of performance on the basis of number of rehabilitations rather than quality standards is recognized as pernicious and defeating.

Sensitivity training is needed to change existing biased or frozen attitudes and to promote more efficient service.

Advocacy and outreach are approached by suggestions for identifying those needing services but not now receiving them. The success of advocacy and outreach would eliminate a major barrier to service delivery.

Multi-service centers located conveniently near poverty stricken consumers of services would provide services without transportation hardships or frustrating visits to several service agencies without obtaining services from any. The need for a closer relationship between hospital and rehabilitation personnel through multi-service centers is also needed.

Recreation needs of the disabled and disadvantaged are critically needed yet largely ignored for many reasons; nevertheless, the therapeutic value of recreation enhancing the well-being of those in need is indisputable. Recreation facilities must be provided.

Another barrier to rehabilitation may be the money given as income for certain disabled by the Aid to the Permanently and Totally Disabled, by Workmen's Compensation, and by Social Security Aid to the Permanently Disabled. One observation is that the provision of this income is seen as rehabilitation in and of itself; therefore, little effort is made to involve individuals receiving these benefits in rehabilitation or habilitation.

Findings and recommendations which reflect administrative concerns follow:

WE RECOMMEND THAT THE GOVERNOR, LEGISLATURE AND STATE COMMISSIONERS DEVELOP A DEPARTMENT OF REHABILITATION TO ADMINISTER ALL EXISTING AND FUTURE REHABILITATION PROGRAMS. PRIORITY: URGENT

> At the present time rehabilitation programs are fragmented among 11 different state departments and many agencies.
>
> There is much overlapping and duplication of service jurisdictions and personnel on the state, local and federal levels of government as well as in the private sector. This results in confusion, service gaps and rivalries, especially in the funding of health and rehabilitation programs, and it

splinters unnecessarily the professional service personnel into narrow jurisdictions with resulting service inaccessibility to the public. Also, services are unnecessarily fragmented according to specific handicaps or goals, e.g., medical rehabilitation, vocational rehabilitation and mental health. These are segregated from each other in such a way that a handicapped person is in danger of receiving only some of the services needed by him although he has a right to them all.

A New York State Department of Rehabilitation which would reorganize existing and future rehabilitation services on a one-stop basis would facilitate the rehabilitation process and save a great deal of waste in professional time and taxpayers' money. The expeditious delivery of services can do much to motivate the client to a better recovery.

The needs of the special handicapped groups should be recognized by special offices and personnel.

Consideration should be given to changes in present legislation and regulations with regard to the various rehabilitation services so that funding would be a more general one which would better fulfill the goals of the specific funding statutes and regulations.

SUFFOLK SHOULD HAVE A REHABILITATION COORDINATOR. PRIORITY: ESSENTIAL

The rehabilitation coordinator should have the qualifications necessary to be knowledgeable about all aspects of physical, psychological, vocational and social rehabilitation. In other words, in addition to being familiar with the needs of the physically and mentally disabled, the coordinator should have detailed knowledge of the problems of the socially, culturally, educationally and economically handicapped. He should be capable of proposing possible solutions to the problem of the handicapped in all the needed categories. He should also be familiar with existing rehabilitation and related services and be capable, in concert with others, of describing gaps in rehabilitation services or facility resources and of taking leadership in initiating action to remedy the unmet facility and services needed.

The coordinator would be charged with the responsibility of helping to insure that the county's official agency funds and personnel allotted to rehabilitation are being utilized as effectively as possible. The coordinator should be attached to and responsible to one of the county's official agencies and have a direct relationship to a rehabilitation planning council.

The coordinator would periodically evaluate and report on all rehabilitation programs in the county, whatever the source of their financing, and help determine the comprehensiveness and quality of the programs to meet the community's needs.

The coordinator would serve as:

- A resource person and consultant to county departments who are involved in any rehabilitation and employment programs;
- Liaison to state agencies involved and responsible for rehabilitation programs in Suffolk;
- Liaison to school districts and Boards of Cooperative Education serving the handicapped in regular or special classes and training programs;
- Liaison to agencies such as manpower training, the Suffolk Economic Opportunity Council and all other agencies that provide rehabilitation and employment programs for the socially, culturally, economically and educationally handicapped.

A SUFFOLK REHABILITATION PLANNING COUNCIL SHOULD BE CREATED. PRIORITY: ESSENTIAL

A planning council, as well as a rehabilitation coordinator, must be accorded recognition, authority and financial support to be effective.

The basic objectives of the planning council and coordinator would be to exert leadership in developing and implementing an overall plan for comprehensive rehabilitation services, and in general, fostering unity and continuity of rehabilitation services provided by Suffolk County's voluntary and public facilities and agencies and related services.

Efforts would be made to insure that any person, regardless of the type of disability, would receive needed rehabilitation services as conveniently and effectively as possible.

In the last analysis, the council would be as effective as the authority accorded it. There is no question that we will not have an effective coordinated total rehabilitation program in Suffolk until such time as there is a body representative of all areas of rehabilitation authorized to describe unmet facility and service needs and pass judgment on the quality of services rendered.

4

The Suffolk Rehabilitation Planning Council might be organized in one of several ways to be effective. The strongest council would be a "commission type" advisory planning group. Membership would be about 10 or 12 appointed by the County Executive from interested and informed individuals, from consumer publics, individuals representing the official and voluntary agencies involved in rehabilitation activities, individuals representing the Community Council, the Suffolk Rehabilitation Council, Interdepartmental Social Welfare Advisory Committee and individuals such as state agency personnel, with demonstrated interest and qualifications in the area of rehabilitation. Members of the Planning Council should represent their agencies to the degree that they can commit their agencies to action or opinion.

It is hoped that the existing Suffolk County Rehabilitation Council, which was established in 1965 "to bring into one organization all professional and ancillary disciplines engaged in the rehabilitation of the physically, mentally, vocationally, socially and intellectually handicapped in Suffolk County," can play a major role through its representative on the suggested Planning Council and, as a consultation resource, serve as an innovative force. We have long advocated that the Suffolk County Rehabilitation Council have closer ties with the Suffolk Community Council and thus bring all aspects of rehabilitation to the attention of a wider audience on a regular basis.

We are not going to make dramatic progress in rehabilitation in Suffolk County unless total individual and agency efforts are blended together more fully. In one sense, the greatest need is the setting of priorities since for all agencies funds and personnel are limited.

IT IS RECOMMENDED THAT THERE SHOULD BE A CONTINUATION OF THE OFFICE OF STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION SERVICES, WITH PROVISION FOR PERMANENT STRUCTURE. PRIORITY: URGENT

CONSUMERS OF SERVICES, NOT ONLY THEIR SURROGATES, MUST BE APPOINTED TO POLICYMAKING BOARDS AND COMMITTEES IN EVERY SERVICE AREA INCLUDING, AMONG OTHERS, JOBS, REHABILITATION, HEALTH, HOUSING AND EDUCATION TO INSURE SERVICE DELIVERY AS WELL AS MEANINGFUL EVALUATION. PRIORITY: URGENT

IT IS RECOMMENDED THAT THERE BE THE CLOSEST POSSIBLE WORKING RELATIONSHIP BETWEEN REHABILITATION SERVICES PLANNING AS IT DEVELOPS IN THE FORM OF REGIONAL MEDICAL PROGRAMS FOR HEART DISEASE, CANCER, STROKE, AND RELATED DISEASES AND COMPREHENSIVE HEALTH PLANNING. PRIORITY: DESIRABLE

THE WESTCHESTER DISTRICT COMMITTEE RECOMMENDS THAT PLANNING FOR REGIONAL SERVICES FOLLOW THE GEOGRAPHICAL STRUCTURE ESTABLISHED BY THE COMPREHENSIVE HEALTH PLANNING COMMISSION WHICH ESTABLISHED A COHESIVE UNIT. THE WESTCHESTER DISTRICT COMMITTEE FURTHER RECOMMENDS THAT ALL STUDIES DONE ON A STATE LEVEL CALLING FOR REGIONAL PLANNING ADOPT THE REGIONAL PLANNING AREAS ESTABLISHED BY THE STATE COMPREHENSIVE HEALTH PLANNING COMMISSION. HIGH PRIORITY

There is need to revise the geographical planning areas for rehabilitation services. The Westchester District Committee finds that Westchester and Rockland Counties are not compatible for regional purposes with Suffolk and Nassau Counties because of the geographical relationship to each other. The Westchester District Committee also concludes that the findings of the State Planning Committee for Rehabilitation Services are of serious import to other areas of State Comprehensive Planning in the field of health and welfare, and should, therefore, relate to a unified regional planning system.

MORE PUBLIC EDUCATION AND DISSEMINATION OF KNOWLEDGE TO ALL IN THE COMMUNITY ABOUT EXISTING PROGRAMS FOR THE HANDICAPPED IS NEEDED. PRIORITY: DESIRABLE

Specifically, there is a need for organized formal programs to educate the public, as well as service agencies in what is available for the handicapped in the county. This would involve periodic literature, public speaking engagements by designated personnel and regular exchanges between agencies, and information and lectures on their various programs. This recommendation is also tied in with the recommendation for a central clearinghouse or exchange information center which could be responsible for this public education function. There should be a professional education program as well. Hopefully this can be implemented prior to the establishment of a coordinator and a rehabilitation planning council but would eventually become part of the coordinator's responsibility.

THERE IS A NEED ON STATE AND NATIONAL LEVELS FOR AN EDUCATIONAL AND PUBLIC RELATIONS PROGRAM TO ENCOURAGE INDIVIDUALS TO ENTER THE HEALTH-RELATED AREAS. IN ADDITION, GREATER USE MUST BE MADE OF TECHNICAL, SUBPROFESSIONAL AND PARAPROFESSIONAL PERSONNEL BY PUBLIC AND PRIVATE AGENCIES. PRIORITY: DESIRABLE

Personnel shortages exist in all the health, welfare and educational fields. Specifically, there is a shortage of social workers, rehabilitation counselors, psychologists and psychiatrists.

BOTH THE STATE AND FEDERAL GOVERNMENTS SHOULD SERIOUSLY CONSIDER THE DEVELOPMENT OF UNDERGRADUATE PROGRAMS IN SOME OF THE MORE ACUTE MANPOWER SHORTAGE FIELDS SO THAT OTHERWISE QUALIFIED STUDENTS MIGHT BE ATTRACTED INTO THESE FIELDS. PRIORITY: DESIRABLE

The undergraduate programs could provide for field work and on-the-job training with the cooperation of state and private agencies. For example, state agencies could set up for a one-year on-the-job training program for four-year college graduates who have otherwise satisfactorily completed a course in rehabilitation counseling on the undergraduate level and who could be employed as rehabilitation counselor trainees while receiving their field work experience with the state agency. Similar programs could be set up in other health-related fields. This plus the development of on-the-job training programs in state and private agencies will increase the opportunities for attracting qualified personnel into the manpower shortage areas.

WE RECOMMEND MORE ADEQUATE SALARIES AND FRINGE BENEFITS IN ORDER TO RETAIN QUALIFIED PERSONNEL IN THE HEALTH FIELDS. PRIORITY: ESSENTIAL

This is especially true in the Westchester County area where the standard of living is substantially higher than other areas of the state or country. Salaries for clerical and office personnel must also be more realistic in Westchester County in keeping with the standard of living and to retain qualified personnel.

WE RECOMMEND THE UTILIZATION OF PARAPROFESSIONALS IN HEALTH AND RELATED SERVICE AREAS. PRIORITY: URGENT

There is no question that there is a shortage of manpower in rehabilitation. This, of course, can be said for any health or related service area. While there is no substitute for agressive recruitment and training in the field of rehabilitation on the professional level, we must take advantage of the ability of people who are capable of serving as paraprofessionals and aides under professional direction, particularly those who are familiar firsthand with the problems of those they serve. Very often we find that many of the problems of maladjustment to daily living lend themselves as readily to solution by paraprofessionals as they do professionals. Present professional requirements should be examined for possibilities of reclassification of duties and developing training for the reclassified jobs.

THERE IS A NEED FOR SENSITIVITY TRAINING TO CORRECT THE FOLLOWING:

- PROFESSIONAL RIGIDITY AND BIGOTED ATTITUDES OF STAFF;
- LACK OF UNDERSTANDING OF THE PROBLEMS OF THE POOR;
- INABILITY OF STAFF TO COMMUNICATE WITH THE POOR;
- MISUNDERSTANDING OF WHAT THE SERVICES ARE DESIGNED TO ACCOMPLISH;
- LACK OF INFORMATION ABOUT AVAILABLE SERVICES AND THEIR LOCATION. HIGH PRIORITY

WE RECOMMEND THAT THE PRESENT SYSTEM OF DETERMINING THE EFFECTIVENESS OF A COUNSELOR'S EFFORT BE REEVALUATED TO PROVIDE A MORE REALISTIC BASIS FOR THE ASSESSMENT OF HIS PROFESSIONAL WORK. PRIORITY: DESIRABLE

At present we may be overly concerned with closures as the hallmark of effectiveness. It is deemed advisable to develop a "weighting system" which would attempt to assign a specific point score to each case in terms of the effort that may be anticipated to achieve a successful conclusion. Such a weighted caseload would reflect more realistically the professional inputs required and would ultimately be reflected in closure.

EFFECTIVE METHODS OF PERSONNEL RECRUITMENT AND TRAINING OF PROFESSIONAL MENTAL HEALTH WORKERS FOR THE DEAF MUST BE DEVELOPED AND FUNDS PROVIDED FOR THEIR EMPLOYMENT. PRIORITY: DESIRABLE

Once these professionals are trained, facilities must be established throughout the state for them to work from, with a view toward providing out-patient mental health facilities for all deaf persons who are in need of such treatment.

THERE IS NEED FOR A SPECIALIZED TRAINING PROGRAM FOR VOCATIONAL REHABILITATION COUNSELING FOR THE DEAF IN AN ESTABLISHED UNIVERSITY IN NEW YORK STATE. PRIORITY: ESSENTIAL

Such a program would encourage interested persons to specialize in this work. Other states give special consideration to the unique needs of the deaf, and rigid requirements are waived to permit some counselors to work on their jobs and go to school on a part-time basis in order to qualify themselves for work with the deaf.

STATE AND FEDERAL GRANTS SHOULD BE INCREASED ON THE POSTGRADUATE LEVEL AND A GRANT PROGRAM INITIATED FOR UNDERGRADUATES, COLLEGES, AND PUBLIC AND PRIVATE AGENCIES, LEADING TO CERTIFYING COLLEGE GRADUATES AS TECHNICAL OR PARAPROFESSIONAL PERSONNEL UPON THE COMPLETION OF THEIR UNDERGRADUATE STUDIES AND A ONE-YEAR ON-THE-JOB TRAINING PROGRAM WITHIN A PUBLIC OR PRIVATE AGENCY FOR THE HANDICAPPED. PRIORITY: URGENT AND LONG-TERM

Salaried subsidies also might be considered in order to retain qualified personnel in the field of the handicapped as practitioners with a minimum of administration-related duties.

WE RECOMMEND THAT A SPECIAL COMMITTEE BE ASSIGNED TO EACH REGION TO EXPLORE IN DEPTH THE COMPLETE IDENTITY, BOTH IN NUMBERS AND CATEGORIES, OF THAT SEGMENT OF THE POPULATION THAT COULD BENEFIT FROM VOCATIONAL REHABILITATION SERVICES. THE DEFINITION OF VOCATIONAL REHABILITATION SERVICES SHOULD FOLLOW THAT DESCRIBED IN THE VOCATIONAL REHABILITATION AMENDMENTS ACT OF 1968. PRIORITY: ESSENTIAL

We emphasize that the provisions of the act give very broad scope to the definition of service and thereby open the door to the vast majority of the handicapped segment in our society.

CONSIDERATION SHOULD BE GIVEN FOR THE ORGANIZATION OF A HUMAN RESOURCES AGENCY WHICH WOULD HOUSE ALL PUBLIC FUNDING RELATING TO REHABILITATION SERVICES RATHER THAN THE PRESENT SETUP WHERE MANY GOVERNMENT AGENCIES ARE INVOLVED IN THE REHABILITATION EFFORT. HIGH PRIORITY

There is overlapping in responsibility at all levels of government and in their service program. With limited funding and differential setting of priorities by all government agencies, service gaps can result with consequent confusion to the consumer of services.

IN THE EMPLOYMENT OF THE HANDICAPPED, PARTICULARLY THE SOCIALLY DISADVANTAGED, WE NEED CLOSER COOPERATION BETWEEN THE SUFFOLK DEPARTMENT OF SOCIAL SERVICES, THE SUFFOLK DEPARTMENT OF LABOR, THE SUFFOLK HUMAN RELATIONS COMMISSION, THE NEW YORK STATE DIVISION OF EMPLOYMENT, THE SUFFOLK ECONOMIC OPPORTUNITY COUNCIL, THE DIVISION OF VOCATIONAL REHABILITATION AND THE SUFFOLK COUNTY REGIONAL CENTER TITLE III INNOVATIVE SCHOOL PROGRAM, EDUCATION OF HANDICAPPED CHILDREN. PRIORITY: DESIRABLE

Whenever possible, the public agencies should determine how they can strengthen, support and utilize the private voluntary agencies to help them better meet the total community and client need. In other words, we are at a time when all recognized rehabilitation agencies should plan together.

Whether a master rehabilitation services and need plan is ever developed, it is imperative that many of the agencies that normally operate in a special sphere be more aware of each other's daily activities. We are not implying that there is not an exchange of information between various agencies, but we are implying that far too often clients face a range of opportunities for services that they cannot comprehend. Very often a continuity of care plan is nonexistent.

WE STRONGLY RECOMMEND THAT AN EFFORT BE MADE TO COORDINATE MORE CLOSELY OR AT LEAST DEVELOP A MORE INFORMAL EXCHANGE OF INFORMATION ON THE MULTITUDE OF PROGRAMS FOCUSING ON THE UNEMPLOYED AND UNDEREMPLOYED. PRIORITY: DESIRABLE

At last count, there were about 28 public and private programs in Nassau and Suffolk designed to provide either job training, job oriented basic education, or initial exposure to the business world.

Some of the programs by title are:

- Manpower Development and Training
- State Training Plan
- On-The-Job Training Program -- Suffolk Labor Department and Human Relations Commission
- Job Corps
- Seasonal Employees in Agriculture
- Federal Apprenticeship Training Programs
- Opportunity High School
- Long Island Lighting Company On-The-Job Program
- Title 5 Program - Social Services Department
- Neighborhood Youth Corps
- Wyandanch - Brentwood Clinics Program
- Islip Summer Youth Program
- Basic Education
- Human Relations Commission Job Counseling and Placement Service

The Cooperative Agency Manpower Planning Systems (CAMPS) has representatives from each organization receiving federal and state funds for these employment programs and meets regularly for purposes of coordination. It is important to know how the Division of Vocational Rehabilitation fits in with the programs offered and if related rehabilitation needs are being met by these programs.

WE RECOMMEND THAT THE CONCEPT OF MULTI-SERVICE, ONE-STOP REHABILITATION CENTERS BE EXPLORED FULLY, PARTICULARLY TO BRING SERVICES TO AREAS WHERE THERE IS A HIGH INCIDENCE AND PREVALENCE OF DISABILITY AS THERE IS IN LOW-INCOME POVERTY POCKETS, AND GHETTOS. PRIORITY: URGENT

As part of this recommendation, we feel that there needs to be a closer relationship between hospitals, particularly general hospitals and rehabilitation services. It seems logical that the subject of rehabilitation facilities and services should be discussed in relation to the possibility of a review of these diagnostic and screening units in hospitals that could be used in the evaluation of clients. The objective of recommendations relating to hospitals and multi-service centers would be to make rehabilitation services more accessible to the client and to improve the continuity of service.

WE NEED AN UNPRECEDENTED SPIRIT OF COOPERATION AND COORDINATION BETWEEN PUBLIC AND VOLUNTARY AGENCIES AND PERSONNEL SERVING IN THE FIELD OF REHABILITATION IN OUR AREA. PRIORITY: DESIRABLE

Obviously, increased appropriations will be needed to support new and expanded services particularly in light of the fact that local funds are clearly limited in our area of rapidly expanded population.

We feel that it is absolutely necessary, if available funds are to be used most economically and productively, that local, state, and where appropriate, federal agencies and personnel work out and follow formal or informal coordinative programs to meet the total rehabilitation needs of Suffolk residents.

We are not suggesting absolute controls which strangle initiative or limit innovation or restrict the independence of agencies, but rather, coordinated planning to prevent a) some agencies from having a low census while others have a waiting list; b) an agency from lacking a reasonable long-term assurance that a referral agency will be sending clients on a regular basis.

It may seem too much to expect, but we feel it is reasonable to suggest that in this context it might be possible to discuss unmet needs and rehabilitation needs openly to determine exactly which agency is in the best position to meet these needs.

IT IS RECOMMENDED THAT AS SOON AS POSSIBLE, REPRESENTATIVES OF ALL AGENCIES IN AND RESPONSIBLE FOR REHABILITATION SERVICES BE CALLED TOGETHER IN A SERIES OF MEETINGS TO HELP DETERMINE THE FULL IMPACT ON REHABILITATION OF SUCH EVENTS AS THE FUTURE OPENING OF THE FIVE MILLION DOLLAR REHABILITATION CENTER AT CENTRAL ISLIP STATE HOSPITAL, THE NEW ADDITION TO THE VA HOSPITAL AT NORTHPORT, AND THE ADVENT OF THE HEALTH SCIENCES CENTER AT STONYBROOK. PRIORITY: DESIRABLE

WE RECOMMEND THAT A SURVEY BE INSTITUTED TO DETERMINE WHAT ROLE INCOME SUCH AS PENSIONS, WORKMEN'S COMPENSATION AND SOCIAL SECURITY PLAYS IN THE REHABILITATION PROCESS. PRIORITY: ESSENTIAL

There is some evidence that in some instances such income may be a substitution for rehabilitation.

There is no question that we do not know the full dimensions of rehabilitation or income need unless we consider and equate that a family of four needs about $10,000 a year to exist moderately, and a retired couple $4,500. Perhaps financial and economic rehabilitation may be a need of greater dimensions than we can imagine.

WE RECOMMEND THAT THE VOCATIONAL TRAINING UNITS AND STAFF OF STATE HOSPITALS AND STATE SCHOOLS BE UTILIZED FOR MEETING THE TRAINING NEEDS OF THE "HARD CORE" DISADVANTAGED DISABLED BY OPENING UP THE VOCATIONAL EVALUATION AND PERSONAL ADJUSTMENT TRAINING UNITS IN INSTITUTIONS TO OUT-PATIENT SERVICES IN THE LOCAL COMMUNITIES. PROVISIONS SHOULD BE MADE THROUGH THE DIVISION OF VOCATIONAL REHABILITATION FOR PAYMENT TO PATIENT-CLIENTS, BOTH IN-PATIENTS AND OUT-PATIENTS FOR WORK ACCOMPLISHED DURING PERSONAL ADJUSTMENT TRAINING. PRIORITY: URGENT

There is a dearth of facilities and staff to meet the longer-term counseling training necessary for placement of the "hard core" disadvantaged disabled.

Utilizing state hospitals and state schools which are able and experienced in handling the problems of the "hard core" disadvantaged disabled would:

- Permit institutions to serve as needed longer-term sheltered workshops;
- Provide institutions with the tool (payment for work done) for the development of a realistic "institution to community employment training program";
- Encourage through budgets a better staffing of the institutions vocational training units (vocational counseling, social service, psychology);
- Provide institutions with adequate service from the Division of Vocational Rehabilitation and the Division of Employment.

THERE IS A NEED FOR A CENTRAL CLEARING OR REFERRAL SERVICE AGENCY IN THE COUNTY FOR THE PURPOSE OF IDENTIFYING AND REFERRING HANDICAPPED INDIVIDUALS TO THE PROPER SERVICE AGENCY. IN CONJUNCTION WITH THIS, A DIRECTORY ON DIAGNOSTIC FACILITIES IS NEEDED IN THE COUNTY IN ORDER TO FACILITATE AGENCIES IN THE PROMPT REFERRAL OF INDIVIDUALS TO THE PROPER AGENCIES. HIGH PRIORITY

Such a list of diagnostic centers would then be made available to all organizations and agencies in the county.

THERE IS A NEED FOR MORE COORDINATION OF EFFORT ON THE PART OF PRIVATE AGENCIES TO ORGANIZE RECREATIONAL FACILITIES AND OUTLETS FOR ALL HANDICAPPED GROUPS IN ORDER TO AVOID DUPLICATION OR FRAGMENTATION OF SERVICES. HIGH PRIORITY.

(See Disability Section on Heart, Cancer, Stroke and Other Medical Impairments)

What Can Be Done Internally By the Rehabilitation Agency To Facilitate Service Delivery

Application for Services

The approach to application for services, with the requirement that a client give the most revealing information to total strangers (who will not be working with the client) appears to have been borrowed from the investigative approach of the New York City Department of Welfare. Most services are free; questions relating to financial need will be asked at the time that physical restoration or the training plan is arrived at, anyway.

In California, in regard to applications for service, almost nothing is filled out by the client in Service Center Intake and there are some questions about whether any application forms should be used.

The rehabilitation agency should use a form which puts minimal responsibility on the client for information-giving. The form should ask:

1. Whether client has a disability;
2. Whether client has another problem that interferes with employment;
3. What help client needs to overcome these problems.

The relevant statement from the Civil Rights Act of 1964 should be given to the client verbally and in writing. Authorizations for information receipt or distribution should be taken.

Eligibility

Eligibility for rehabilitation services is an area of much concern in the community. Little has been done to clarify and simplify this requirement for service. Perhaps a standard, such as the inability of an individual to function or compete in his environment should be developed. The possibility of caprice, dilatory decision or other non-objective barriers influencing a client's access to services should be eliminated. Sensitivity training to assist communication with populations served should be a part of this new approach to service delivery.

Careful attention must be given to new coverage and benefits in the amendments to the Vocational Rehabilitation Act affecting families of clients, public offenders, migratory workers and the disadvantaged. A clear policy for eligibility should be developed within this framework.

Professionalization, Staff Development

Attitudes, reflecting institutionalized bureaucratic depersonalization towards those seeking service can be changed by:

1. Acceptance of advocacy by professional and paraprofessional staff as required agency function;
2. Professionalization of staff through:
    a. Remotivation training;
    b. Inter- and intragroup exchange of resources;
    c. New and different uses of the same services;
    d. Sharing ingenious ways of working with clients and the problems they present to facilitate effective resolution;
    e. Restatement of responsibility of professionals to share information and resources followed by meaningful implementation;
    f. Sharing commendation, appreciation, special mention when staff does a good job and providing more effective training to encourage better levels of performance;
    g. Discontinuing practice of prima facie reprimand of counselor before all sides to a complaint have been heard;
    h. Provision of sensitivity training and/or other effective training to all staff to encourage goal-directed communication with populations served and to vitiate effects of culture shock.

Outreach

Effective outreach programs can be instituted at once by:

1. Assigning staff to existing multi-service centers and Office of Economic Opportunity Programs in the various counties;
2. Assigning staff to Community Mental Health Boards;
3. Establishing a speakers bureau to directly acquaint community groups with Division of Vocational Rehabilitation services and consider advertising, radio and television programs.

Maintenance

Arbitrary and capricious decisions regarding maintenance allowances should be eliminated. Uniform and required standards for maintenance must be developed and they must be uniformly applied. As now used, many clients withdraw from service as they are unable to maintain themselves during training, regardless of beneficial long-term or short-term goals. Not all desire or are eligible for public welfare. Others can go to college in Europe and receive more American dollars in maintenance per week (plus trips back and forth across the Atlantic Ocean) than the average family workingman in the country takes home each week. Electronic data processing must be used to facilitate delivery of checks to clients.

At the outset, established federal guidelines should be adopted.

Client Training Resources

Every client should be entitled to the best possible training facilities for the area he has selected. This will require more knowledge of available resources in and out of the community and the application of objective referrals to schools and facilities that might be underutilized at present or who have never seen a Division of Vocational Rehabilitation client.

The development of industrial resources for training need to be given a high priority. The Urban Coalition, J.C.'s, N.A.B., I.C.B.O., J.O.B.S. and other industrial organizations should be brought into the rehabilitation training and placement areas. Voluntary agencies and religious organizations should also be utilized. High intensity training programs such as those developed at Skills Advancement must be utilized.*

Staffing

To fill critical needs for staff, a Career Ladder Program** should be developed at once as follows:

1. Rehabilitation Service Aide
2. Rehabilitation Service Assistant I
3. Rehabilitation Service Assistant II
4. Assistant Rehabilitation Counselor Associate

INTERAGENCY COORDINATION OF PROGRAMS

The State Employment Service

The Harbridge House Report a few years ago indicated that six percent of the handicapped are placed in jobs by the State Employment Service. Using new approaches and methods in placing the handicapped would at the outset require closer cooperation between the employment service and rehabilitation agencies in sharing job orders, job development and job follow-up and adjustment. It also would provide a new opportunity for selection of training areas as well as placement, such as the use of computers and technology.

The feeling that the existing staff is inadequate to serve those handicapped ready for placement is rather general in both agencies. Also because it is the "hard core" disabled group most in need of services, the selective placement counselor/interviewer should have the function of servicing this group.

Social Services

The inadequacy of social services for those with chronic diseases and severe disabilities is noted. This disparity is also seen in the relationship of the numbers of catastrophically poor who are not receiving welfare; in some areas only ten percent of those in the poverty group eligible for social services are actually receiving benefits. The medical profession, in and out of hospital or clinic settings, as well as social workers and other health personnel are also seen as persons who have the responsibility for referral to social services, yet who rarely perform this obvious and beneficial service.

Health Services

The hospital of the future is seen not as an acute treatment center but rather as a health care center with facilities for rehabilitation and long-term health care in the community. Also, recognizing that comprehensive rehabilitation centers may not always be convenient for many of those who need service, a county transportation system is recommended.

*See p. 217

**See Appendix A for California Career Ladder personnel specifications.

The State Department of Health should not only have a more effective role in the early identification of treatment of disability in infants and children, but also in providing counseling centers for children and their families to provide needed services and to prevent irreversible damage or disability. A central clearing or referral agency is seen as an adjunct to effectuate services.

Other Services

A data bank or central collection, storage and retrieval system is indicated as a resource for coordinating and evaluating public and private services themselves, as well as the services the individual client receives. Proper safeguards to prevent abuse of privileged information should be provided. Research and statistical information for planning purposes could be a positive gain as well as a county resource directory.

Studies of existing rehabilitation services and the effectiveness of primary and secondary rehabilitation centers in the region are needed. A regional workshop is requested to develop uniform reporting systems for manpower economies.

Community volunteer services should be coordinated, and a public relations program established to assist the disabled to live in the community. A need also exists for long-term productive environment which could be provided through half-way houses.

Recommendations for interagency coordination of programs follow.

WE RECOMMEND THAT JOB ORDERS AND JOB LEADS IN EVERY LOCAL NEW YORK STATE EMPLOYMENT OFFICE BE MADE READILY AVAILABLE TO PROFESSIONAL STAFF OF THE STATE VOCATIONAL REHABILITATION AGENCY UNDER A MUTUAL AGREEMENT. PRIORITY: ESSENTIAL

There is a need to develop better utilization and cooperation between the New York State Employment Service and the State Vocational Rehabilitation Agency. Under present procedure the State Employment Service does not have adequate placement personnel to handle all of the referrals made for selective placement. This would result in more effective placement, especially placement of the more severe disabilities such as the blind and the deaf.

WE RECOMMEND THAT WITHIN THE NEW YORK STATE EMPLOYMENT SERVICE SOME OF THE SELECTIVE PLACEMENT COUNSELORS SHOULD BE ASSIGNED SOLELY TO THE COUNSELING AND PLACEMENT OF THE SEVERELY DISABLED. PRIORITY: DESIRABLE

There is a group of disabled individuals for whom employment has been a very difficult objective. The severely disabled may be found on the rolls of most of the public agencies and include the severely physically disabled, the so-called "unmotivated" or "inadequate personality" of some welfare clients, the legally handicapped probationer and parolee, the trainable retardates, the mentally ill, and the multi-disabled individuals.

Presently within the Division of Employment, the staff of "interviewers" are involved in many programs, and selective placement of the handicapped is one more assignment to an interviewer.

WE RECOMMEND THE ESTABLISHMENT WITHIN EACH COMMUNITY OF APPROXIMATELY 100,000 POPULATION, A REHABILITATION CONSULTANT TEAM COMPOSED OF PHYSICIAN, PUBLIC HEALTH NURSE, SOCIAL WORKER, PSYCHOLOGIST, VOCATIONAL REHABILITATION COUNSELOR, EDUCATOR, PHYSICAL AND OCCUPATIONAL THERAPISTS, AND OTHER SPECIALISTS AS NEEDED. PRIORITY: URGENT

This team, selected from the various public and voluntary health agencies within the community would:

- accept referrals of all those individuals rejected by individual agencies;
- evaluate an individuals' assets and liabilities;
- plan a program of rehabilitation;
- recommend referral to the agency or agencies best suited to meet the individuals' immediate needs;
- follow-up the recommended program and provide periodic re-evaluation of the client/patient for necessary changes in goals.

THERE IS A NEED FOR MORE SOCIAL SERVICES, AND IN ADDITION, BETTER COORDINATION WITH MEDICAL CARE TO MEET FINANCIAL NEEDS OF HEART, CANCER, STROKE PATIENTS. PRIORITY: URGENT

Ten percent of the heart, cancer and stroke patients who need financial assistance, for example, have not received this service.

CONSIDERATION SHOULD BE GIVEN TO RE-EXAMINING THE SEPARATION OF MEDICAL REHABILITATION AND VOCATIONAL REHABILITATION SERVICES. HIGH PRIORITY

There are many instances in which these services may be developed within the same facility. Planners in health care areas say that the concept of a hospital and its functions will undergo great revision in the years to come. The hospital will lose its current image of an acute care facility and will provide services for intermediate and long-term care, a full range of rehabilitative services, home care services and educational services. The hospital of the future will be a health care center rather than an acute hospital center. Within this concept the inclusion of vocational rehabilitation services will be much more appropriate.

WE RECOMMEND THAT A COUNTYWIDE SYSTEM BE ESTABLISHED FOR TRANSPORTING SEVERELY DISABLED PERSONS TO AND FROM WORK AND/OR TO AND FROM REHABILITATION TREATMENT FACILITIES. PRIORITY: URGENT

The recommendation of the study of workshops completed by the Westchester County Council of Social Agencies was that there needs to be developed in Westhcester County Comprehensive Rehabilitation Center Programs which would provide for multiple disability groups and that the location of such centers would depend upon population density, transportation problems and available resources. It is our strong feeling that highly developed services cannot be developed at every street corner, but that the development of a sound transportation program to bring the disabled to centrally located facilities is essential in view of the personnel and other shortages we face. An example of a suggested transportation program is "Wheels for the Handicapped" which was discussed in detail in the Disability Section on the Disadvantaged-Social and Economic Disability, p.184.

WE RECOMMEND THAT THE STATE DEPARTMENT OF HEALTH BE EMPOWERED TO CONDUCT AN EARLY IDENTIFICATION OF HEARING IMPAIRED CHILDREN BY AN INFANT TESTING PROGRAM AND TO ESTABLISH A CENTRAL REGISTRY WITH POWER AND STAFF TO MAKE REFERRALS. PRIORITY: ESSENTIAL

The rationale for such programs is that early identification is especially vital for the sensorily handicapped, particularly the deaf, because of the vital role of the senses in the learning and development of a child. For the severely hearing impaired, speech and language development are at a standstill until the child receives auditory aides, training and language development through special education. Early training can minimize the development of additional handicaps of a functional nature which only serve further to retard the child's rehabilitation, and there will be less waste of the critical periods and opportunities for the child's development. Otherwise, irrevocable damage may result from lack of treatment during this crucial period of growth and language and communication processes will be seriously affected.

WE RECOMMEND THAT MORE EFFECTIVE USE SHOULD BE MADE OF GENERIC COUNSELING CENTERS BY ALL AGENCIES IN SERVING HANDICAPPED INDIVIDUALS AND THEIR FAMILIES. IN ADDITION, THERE IS A NEED FOR MORE OF THESE COUNSELING CENTERS. PRIORITY: DESIRABLE

Vocational rehabilitation can do much to bring about the utilization of the new law which empowers the agency to purchase services needed by the families of those in need of vocational rehabilitation. It should be agency policy to begin this service in conjunction with health and medical rehabilitation and to continue it as needed throughout the special education years of youngsters.

THERE IS A NEED FOR A CENTRAL CLEARING OR REFERRAL SERVICE AGENCY IN EACH COUNTY FOR THE PURPOSE OF IDENTIFYING AND REFERRING ANY HANDICAPPED INDIVIDUAL TO THE PROPER SERVICE AGENCY. PRIORITY: DESIRABLE

In conjunction with this, a directory of diagnostic facilities is needed in order to facilitate the prompt referrals of individuals to the proper agencies. Such a list of diagnostic centers would then be made available to all organizations and agencies in the particular county.

WE RECOMMEND THAT A DATA BANK OR A SYSTEM OF CENTRAL COLLECTION, STORAGE AND RETRIEVAL BE ESTABLISHED FOR INFORMATION ON REHABILITATION CLIENTS AND SERVICES. CLIENTS MIGHT BE IDENTIFIED FOR RECORD KEEPING PURPOSES BY SOCIAL SECURITY NUMBER, WITH PROPER SAFEGUARDS TO AVOID ABUSE. PRIORITY: DESIRABLE

No meaningful data collection system exists at the present time. Asking for routine information can bring forth a blank stare, meaningful presentation of individual agency data, or delays in providing information requested.

Regular reports on rehabilitation services and characteristics of clients served should be stored in a central repository and interpretations and summaries made on a regular basis.

In recommending a data bank, we are concerned with getting a picture of the total rehabilitation effort in the county. We have to assume that individual agencies make appropriate reports on their activities to parent bodies and official agencies on at least an annual basis. We also realize that a standard reporting system would have to be developed to obtain an overall picture.

It is particularly important that data collection activities be coordinated. For example, the New York State Narcotics Addiction Control Commission is beginning a census of addicts and related studies. It would be most helpful if this study and five or six other studies now underway, including a labor survey, were listed in a central source for reference.

WE RECOMMEND THAT A WELL-PUBLICIZED AND CENTRALIZED COUNTYWIDE INFORMATION AND REFERRAL SERVICE BE ESTABLISHED WHICH WILL COLLECT AND COORDINATE INFORMATION ON VOCATIONAL REHABILITATION RESOURCES FOR ALL HANDICAPPED AND VOCATIONALLY DISADVANTAGED PERSONS. HIGH PRIORITY

Incorporating this service within the Division of Vocational Rehabilitation or another established agency is suggested with local citizens advisory groups assisting in the process. A directory would serve to implement the service.

WE RECOMMEND THAT AN INVITATIONAL WORKSHOP CONFERENCE BE SET UP ON A REGIONAL BASIS, WITH A CULMINATING STATEWIDE CONFERENCE, FOR THE PURPOSE OF EVOLVING A UNIFORM SYSTEM FOR ALL AGENCIES PROVIDING REHABILITATION SERVICES OR REFERRING CLIENTS TO SUCH SERVICES. PRIORITY: DESIRABLE

Consultation provided to agencies on setting up a functional retrieval system utilizing uniform systems would result in a valuable contribution in the economy of health manpower time, future planning and evaluation.

WE RECOMMEND THAT AN EVALUATION COMMITTEE BE ESTABLISHED TO ASCERTAIN THE EFFECTIVENESS OF PRIMARY AND SECONDARY REHABILITATION CENTERS IN MEETING THE NEEDS OF PUBLIC AGENCIES. PRIORITY: DESIRABLE

One criterion to use in this evaluation would be the quarterly reports of these centers. A Westchester district committee concludes that without staff services adequate collection and compilation of primary and secondary material is not possible. The material collected by the district committee during the time of its deliberation, for example, does not represent an accurate or thorough picture of the conditions or services in the area.

The district committee recommends that indepth studies in the various subjects covered by this report be authorized by the state and supported with adequate funds and sufficient staff.

WE RECOMMEND THAT A NEW POSITION OF "STATE CONSULTANT FOR COMMUNITY VOLUNTEER SERVICES" BE ESTABLISHED, WITH THE CONSULTANT'S MAJOR RESPONSIBILITY THE PROMOTION OF COMMUNITY VOLUNTEER SERVICES TO ASSIST THE DISABLED TO LIVE AGAIN WITHIN THE COMMUNITY. PRIORITY: DESIRABLE

The coordination of community volunteer effort would do much to bridge the difficult transition between the hospital and/or institution and home.

THE SCHOOLS AND REHABILITATION

There is strong feeling that current approaches and methods of educating the disabled from infancy through adulthood are inadequate and unequal. Rather than educating the individual to be a socially useful person, there is widely held concern that the disabled are being educated for isolation. It is recognized that existing inadequacies in special education services result in functional retardation when communications impaired children, and others who are deprived, cannot or do not receive quantitative or qualitative diagnostic and corrective services in the schools which would prevent irreversible damage and disability to themselves and ultimately the social structure. Our society can only benefit from the integration of disabled and deprived persons, rather than relegating these individuals to a sub-culture with attributes that defy the basic components and elements of humanity.

Much has been done, though not nearly enough, to raise standards for training and developing innovative teaching methods and techniques for salvaging the most precious commodity on earth: human beings. Little has been done to educate parents to understand and assist the acceptance and treatment of disability, or even to become aware of existing laws, services and benefits designed to alleviate the collective miseries and deep-seated traumas imposed by disability. Special education must recognize the involvement of the family group in disability. Even in a society dominated by a military-industrial complex, the enhancement of this structure provided by the compounded dollar value of independent, self-supporting producers of private wealth should be incentive enough to invest more time, health and adjunctive services, ingenuity, creativity, education and training to decelerate the production of consumers of public wealth. The basic component is education - education across the board and beginning with birth.

Disabled infants must receive proper and early diagnosis and treatment as well as education. The therapies of their learning are ripples outward to the shores of society through their family security and structure. The gains are mutually reinforcing. So are the losses that the hiatus or absence of such services produce.

Preventive counseling is an important factor in maintaining stability and providing resources for services and hygiene. Continued counseling, personal and vocational, is needed for high school students, dropouts and others. Vocational rehabilitation services ought to be available at an earlier age to students. Also information regarding services must be made available to the schools.

School administrators and personnel must be made aware of their responsibility to ask for and accept help for the disabled youth. There are still too many principals who state flatly, "we do not have any of those" when the Division of Vocational Rehabilitation counselors present service opportunities and ask for referrals of disabled students. Communication as well as cooperation is a sine qua non for the Division of Vocational Rehabilitation and the schools. In addition to rehabilitation counselors, clinical teams should be attached to school systems to enhance the traditionally accepted role of the educator. The complete organizational involvement of school boards and administration must be encouraged to increase positive interaction with rehabilitation and health service areas. These and other recommendations follow.

WE RECOMMEND THAT BETTER AND MORE EFFECTIVE TEACHING AIDS AND TECHNIQUES BE DEVELOPED TO FIND NEW AND BETTER WAYS TO TEACH THE HANDICAPPED CHILD. PRIORITY: URGENT

The education process should utilize the teaching aids and techniques developed in the course of vocational rehabilitation services to the adult handicapped.

WE RECOMMEND THAT THE 90 PERCENT REIMBURSEMENT FORMULA IN EFFECT FOR TRANSPORTATION BE EXTENDED TO SPECIAL EDUCATION PROGRAMS BOTH IN THE PUBLIC SCHOOL SYSTEM AND IN THE PRIVATE SCHOOLS SUPPORTED BY EDUCATION LAW #4403. SOCIETY WILL NOT RECEIVE HANDICAPPED PERSONS AS AN INTEGRAL PART OF ITS POPULATION IF ITS MEMBERS DO NOT EXPERIENCE GROWING UP WITH THE HANDICAPPED DURING THE CHILD'S IMPORTANT YEARS OF FORMATION.

A great deal of the good work which our public school systems were doing in the development of integrated programs for handicapped children was interrupted by the eradication of special aid formulas which supported these programs. The new simplified formula of state aid to school districts has taken away the incentive of school districts to continue such costly programs. Yet, the programs for handicapped children were less costly than other state-supported special education programs.

All of the other efforts to integrate handicapped persons into our total environment will be lost to society if handicapped children cannot gain the experiences needed to make them more socially acceptable persons.

WE RECOMMEND A MORE EFFECTIVE INTEGRATION OF THE HANDICAPPED CHILD INTO THE REGULAR PUBLIC OR PRIVATE SCHOOL SYSTEM AT THE EARLIEST FEASIBLE AGE. PRIORITY: URGENT

More effective use must be made of the public and private school systems for the education and training of handicapped children.

WE RECOMMEND THE DEVELOPMENT OF SPECIAL PERSONNEL AND PROGRAMS FOR THE BLIND AND VISUALLY IMPAIRED AS WELL AS THE DEAF AND HARD OF HEARING WITH SUCH SUPPORTIVE SERVICES AS LIP READING, AUDITORY TRAINING, SPECIAL EDUCATION TUTORING, SPEECH MONITORING, BRAILLE WRITING, AS WELL AS COUNSELING TO PARENTS. PRIORITY: URGENT

There should also be special remedial reading and language development classes for those children who are inadequate in this area. Integrated deaf children and blind children should have the services of an itinerant teacher for several hours a week at least, in the beginning if not throughout their integrated placement.

WE RECOMMEND THAT PREVOCATIONAL AND VOCATIONAL TRAINING OPPORTUNITIES BE DEVELOPED IN THE DAILY SCHOOL PROGRAM FOR DEAF STUDENTS. PRIORITY: ESSENTIAL

The trend toward an all academic curriculum in the deaf schools has not been successful for a number of students. Deaf students need and would profit greatly from work-study programs. A vocational education consultant is recommended as an addition to the staff of the State Education Department's Bureau of Physically Handicapped Children.

Work-study programs would give deaf students two to four years of half-time prevocational and vocational training under vocational rehabilitation along with the same number of years of half-time academic work. With the academic program related and oriented to a vocational training program, possible student dropouts might have a greater incentive for the academic program. With a student's greater academic achievement and vocational potential, the community, the schools and vocational rehabilitation services would benefit.

WE RECOMMEND THAT THE BEGINNING AGE FOR THE EDUCATION OF THE BLIND AND VISUALLY IMPAIRED CHILD SHOULD BE THREE. PRIORITY: URGENT

There are inadequate services available for all preschool communication impaired children. There must be opportunities for effective diagnostic teaching of these children at the preschool level since they are so badly in need of development or corrective services.

Three is the present beginning age for the education of the deaf and severely hearing-impaired child, but the advances made in the special education of these children indicates that it is vital that the age for the beginning of his education should be the chronological or school year in which he reaches his second birthday.

WE RECOMMEND THAT MORE PRESCHOOL PROGRAMS BE ESTABLISHED FOR ALL HANDICAPPED CHILDREN, ESPECIALLY MULTI-HANDICAPPED CHILDREN, AND THOSE WHO ARE CULTURALLY AND ENVIRONMENTALLY DEPRIVED. PRIORITY: ESSENTIAL

If the Legislature is reluctant to change the present age for beginning school for all children, and is fearful of how to specify such a change for the handicapped child without opening the gates to all children, the solution may be the vocational rehabilitation services which are now available by law to handicapped or deprived children. Preschool services could be provided by the Vocational Rehabilitation Services if the state and federal government would make the necessary financial appropriations.

RESOURCE TEACHERS SHOULD BE AVAILABLE TO ALL SCHOOL DISTRICTS WHICH NEED SPECIALIZED INSTRUCTION FOR HANDICAPPED CHILDREN. THE EDUCATIONAL SYSTEM OR HEALTH, WELFARE OR REHABILITATION PROGRAMS SHOULD PROVIDE AMPLE PERSONNEL IN EACH COMMUNITY TO INSTRUCT MOTHERS AND FATHERS OF HANDICAPPED INFANT CHILDREN ON WAYS FOR THEM AND OTHER FAMILIES TO COMMUNICATE WITH THEIR CHILDREN. PRIORITY: ESSENTIAL

The preventive counseling concept is basic to the pupil personnel practices of school systems for school age children. There exists a lack of resource teachers, counseling services and treatment facilities for multi-handicapped children and for their parents. Ways must be found to make the preventive counseling services available to the sensorily deprived child and his family as early as possible if permanent damage is to be prevented.

THERE NEEDS TO BE MORE EFFECTIVE COMMUNICATIONS BETWEEN SCHOOL SYSTEMS AND REHABILITATION FACILITIES. A FORMAL AND ORGANIZED REFERRAL PROCEDURE BETWEEN THE SCHOOLS AND HEALTH AND WELFARE FACILITIES WOULD GIVE THE HANDICAPPED CHILD MAXIMUM UTILIZATION OF EXISTING RESOURCES IN SCHOOLS AND IN REHABILITATION PROGRAMS. PRIORITY: HIGH

THERE IS URGENT NEED FOR THE STATE VOCATIONAL REHABILITATION AGENCIES, BOTH THE DIVISION OF VOCATIONAL REHABILITATION AND THE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED, TO PROVIDE MORE COUNSELING ASSISTANCE TO JUNIOR AND SENIOR HIGH SCHOOL STUDENTS. PRIORITY: URGENT

As training opportunities and employment needs become more sophisticated and complex, there is a greater need by the schools for technical assistance from state rehabilitation counselors in planning for their students' future training and employment opportunities.

With the blind, deaf, hard of hearing and other communicative handicapped there is increasing pressure from the high schools for the state agencies to provide vocational counseling services at the earliest possible age or grade level, beginning preferably around the age of twelve or thirteen, or the ninth grade level. There are many services, including counseling and guidance, course planning, vocational evaluation, personal and social adjustment, and the development of communicative skills, which can be rendered in the early teen age if appropriate state agency staff were made available for this purpose.

This goal cannot be accomplished unless there are increases in the budget for additional staff, and for the purchase of services needed by students at the age level indicated as necessary for true and maximum vocational achievement and adjustment.

A first step toward a strong interrelationship between education and vocational rehabilitation should be at the state level with the introduction of a special education consultant whose task would be to train school-related vocational counselors so that they would be properly oriented to the techniques and curriculum of the schools and appreciate the problems and difficulties involved in the development of handicapped youngsters to achieve their maximum potential.

The special education consultant who directs the school-related counselors should have a community organization background, if possible, since a vital part of his role would be the mobilization and development of generic counseling agencies as resources for the child and his family. The new legislation empowering the purchase of counseling services for families will be fruitless unless there is staff to implement the delivery of these services and close coordination with the schools and the school-related vocational counselor.

WE RECOMMEND THAT PART-TIME ATTENDANCE IN A COMMUNITY VOCATIONAL REHABILITATION FACILITY FOR THE EMOTIONALLY DISTURBED BE PROVIDED. PRIORITY: URGENT

A work-study program would provide disturbed teenagers still in high school with more meaningful programs and result in ultimate job placement.

MENTAL HEALTH CARE SHOULD BE PROVIDED FOR THE EMOTIONALLY DISTURBED TEENAGER OR SCHOOL DROPOUT. PRIORITY: URGENT

IT IS RECOMMENDED THAT CLINICAL TEAMS BE ATTACHED TO PUBLIC SCHOOL SYSTEMS TO PROVIDE SUCH CONSULTATION AS WILL ENABLE THE EDUCATIONAL STAFF TO EXPAND THEIR CONCEPT OF EDUCATION. PRIORITY: HIGH

The public school systems in Westchester County have acknowledged their limitations in providing programs for the severely disturbed and retarded child.

A basic understanding of the psycho-dynamic factors involved in individual children and children in general would enable the educator to plan for and carry out education programs with the objective of improving total functioning.

WE RECOMMEND THAT THE DIVISION OF VOCATIONAL REHABILITATION PROVIDE A LIAISON TO THE STATE DIRECTOR OF HEALTH EDUCATION IN ORDER TO DISCUSS WAYS IN WHICH ANY HEALTH EDUCATION CURRICULUM THAT IS DESIGNED BY HIM SHALL INCLUDE PREVENTIVE ASPECTS OF HEART, CANCER AND STROKE AND THE BUILDING OF POSITIVE ATTITUDES TOWARD THE HANDICAPPED. PRIORITY: URGENT

THE STATE EDUCATION DEPARTMENT'S BUREAU OF PHYSICALLY HANDICAPPED CHILDREN NEEDS THE ADDITION OF A VOCATIONAL EDUCATION EXPERT TO ITS STAFF FOR THE DEVELOPMENT OF ACADEMIC AS WELL AS VOCATIONAL EDUCATION CURRICULUM THAT WOULD PREPARE HANDICAPPED CHILDREN, ESPECIALLY THE SENSORILY DEPRIVED, FOR THE REALITIES OF VOCATIONAL LIVING AND THE POSSIBLE GOALS FOR THEM IN THIS WORK-A-DAY WORLD. PRIORITY: ESSENTIAL

Much has been developed in the way of teaching aids and other technical or mechanical aids for the handicapped on post-educational and adult levels which would be effectively used in curriculum planning.

WE RECOMMEND MORE EFFECTIVE UTILIZATION OF THE VOCATIONAL TRAINING FACILITIES OF BOARDS OF COOPERATIVE EDUCATIONAL SERVICES BY THE DIVISION OF VOCATIONAL REHABILITATION. PRIORITY: DESIRABLE

In some areas cooperation between these two divisions seems to be based on personal rapport and not on Department of Education policy or procedure. Positive gains in service delivery is one of the more desirable objectives of such joint effort.

FINDINGS AND RECOMMENDATIONS: MANPOWER, LABOR AND INDUSTRY

A major objective of rehabilitation, in addition to providing an individual with the opportunity and service for maximum mental or physical functioning, is to support the manpower objectives of our military-industrial complex.

In New York State during 1964-65, of 48,693 cases handled by the Division of Vocational Rehabilitation, 28,824 were in active service during the year, and 8,505 were rehabilitated. About 85 percent of the rehabilitants were unemployed, with no dependents, and were supported by family or friends. Only 10 percent were on public relief. The largest number were referred by hospitals and clinics; the next largest number by schools. About 28 percent were mentally ill; the rest had physical impairments.

Prior to rehabilitation the clients' annual earnings were 3.7 million dollars. After rehabilitation, their annual earnings were 24.5 million dollars. The cost of case services was 5.5 million dollars. However, the 8,505 rehabilitated persons will return to the community in income taxes alone for the first year after rehabilitation, an amount exceeding 43 percent of the costs for case services.*

What were the jobs held by clients after rehabilitation? The publication Facts in Brief reveals the following:

307	or	3.6%	-	professional
267	or	3.1%	-	semiprofessional
192	or	2.3%	-	managerial and official
2,003	or	23.6%	-	clerical and kindred
327	or	3.8%	-	sales
1,194	or	14.0%	-	service
182	or	2.1%	-	agricultural and kindred
837	or	9.8%	-	skilled
1,260	or	14.8%	-	semiskilled
661	or	7.8%	-	unskilled
127	or	1.5%	-	family workers**
1,148	or	13.5%	-	homemakers
8,505		100%		total

Of the 8,505 rehabilitated, 217 or 2.6% were self-employed, and 498 or 5.9% were placed in sheltered workshops.

A projection of manpower requirements to 1975 in New York State shows that certain occupations and areas of work will increase, e.g., jobs that require only an elementary school education:

> At the other end of the scale there will be more jobs that require only an elementary school education than there will be persons who have gone no further than this in school. Such persons are mainly in-migrants from Puerto Rico and from the southern states. Presumably this excess of demand over supply means that some people with some high school education will be hired for these jobs. So far as the one-to-three-years-of-high-school level is concerned, there will be more persons than jobs. If the elementary school group and the one-to-three-years-of-high-school group are combined, there is a near balance between demand and supply even though the jobs are poor and unattractive ones and even though some of the applicants have more schooling than the jobs require.***

The estimates do not support the notion that there are or will be in the years immediately ahead an inadequate number of jobs for poorly educated persons. The reverse is true. The professions, certain clerical areas and certain skilled areas will also be in demand.

---

*Source: Facts in Brief, No. 1, New York State Education Department, Division of Vocational Rehabilitation, June 1965.

**The term "family worker" applies to persons who work for maintenance only on a family farm or in a family business operated by a relative living in the same household as the family worker.

***Source: Manpower Directions, New York State Department of Labor, Division of Research and Statistics, New York State, 1965-1975

In preparing clients for the job market, it is important for counselors to know that increased use of quick copy equipment, dictating equipment and the like, which will expand productivity, will reduce the need for office workers performing relatively routine tasks. The spread of electronic data processing, automatic record-keeping processes, automatic reading devices, inter-office electronic communication and microfilm record keeping will reduce relatively the amount of manual office operations, resulting in fewer bookkeeping and other machine operators, key punch operators, statistical clerks, file, payroll and billing clerks and similar jobs. In the apparel industry, a decrease in semiskilled textile and apparel occupations is predicted.*

Still another area in which manpower requirements may change is in the area of health needs. A critical evaluation of health needs and available training resources indicates a gross inability to produce enough doctors to serve the population by 1975. At the University of Colorado Medical Center a new occupation, the pediatric nurse practitioner, has been developed from the functions of a physician specializing in diseases of childhood.

Called the "Child Health Associate Program," the Medical Center will train an entirely new group of health workers who would be associated with physicians in giving diagnostic, preventative and therapeutic services to children. The program will effectively prepare such workers in a period of five years from the time of graduation from high school until they are ready to go into "practice." At the end of this five-year education and training experience the Child Health Associate will be qualified to care for more than 80 percent of all patients now being seen by pediatricians according to the Medical Center in Denver.

In addition to preparing clients for changing job markets and changing manpower requirements, new approaches are also necessary to retool or retire technologically backward rehabilitation training facilities which use obsolete equipment, approaches and techniques.

Skill Advancement, Incorporated provides what is called high intensity training applied to employees by:

- **determining through job task analysis the true skill requirement of a target job;**
- **distilling traditional training to accomplish training objectives in less time than usual for these jobs;**
- **custom designing training programs to meet the particular manpower needs of the individual organization;**
- **involving supervisors and other key personnel to modify fixed attitudes towards low-skill, low-wage workers;**
- **understanding and meeting management and union objectives.**

The trainee is considered (1) in his total environment at home, work and in the community, (2) recognizing his unique socio-economic, physical and psychological needs as they relate to job performance, (3) developing his self-confidence, self-actualization and ego strengths, combining them with skill training in a mutually-reinforcing synthesis. Constants in real living include instructions in benefits and application of Medicare, Medicaid, Social Security, loans, liens, garnishees, credit buying, consumer information, business etiquette, communication skills, arithmetic, human relations. A tracking system follows up, stabilizes and evaluates the trainees' progress and the program itself in relation to the trainees. In-plant professional industrial trainers are an integral part of the tracking system. These approaches and techniques, developed by Cornell University, the New York Urban League, and the Puerto Rican Forum, have been utilized by some of the nation's largest employers: The City of New York, Standard Oil of New Jersey, and, in Region II, Grumman Aircraft Engineering Corporation.

The information which follows, resulting from an August, 1968 interview at Grumman Aircraft Engineering Corporation is concerned with three areas of manpower utilization geared toward the new provisions of the Vocational Rehabilitation Act Amendments 90-391 relating to the disadvantaged: the unemployed, the underemployed, and the hard core groups.

***See Tables on p. 222 & 224 for Target Populations, Division of Employment, and Region II Jobs By Industry. See also Appendix B.**

****Interview with Mr. Peter Van Putten, Chairman, Power, Labor and Industry Committee, Region II; Assistant Director of Personnel, Grumman Aircraft Engineering Corporation.**

Grumman Aircraft Engineering Corporation employs 36,000 workers and is one of the largest employers in Region II and in the country. Mr. Peter Van Putten, Assistant Director of Personnel at Grumman, has been a participant in the Columbia Broadcasting System's television program, "Opportunity Line." For this program he committed 25 job openings, all of which were filled. The jobs were filled by 25 employees who commute from New York City using a car pool. They represent workers with basic skills, those who are semiskilled and highly skilled. The group was upwardly mobile and did not represent the hard-core unemployed. The production rate of the group, most of whom are black people, is good or above average. There is little tardiness and no absentee problem. Turnover is minimal, much less than average. However, Mr. Van Putten feels that he sees no clear model emerging from the Grumman program. He feels that each individual industrial firm has to approach the problem of working with the disadvantaged within the terms of its own policies and structure.

Under a new program, according to Mr. Van Putten, Grumman has plans to hire 300 hard-core unemployed in a cycle of 30 each month. Those hired will become employees of Grumman at the time they are hired: there will not be the usual employment prerequisites. Therefore, in essence there will be no screening. In the past, Mr. Van Putten states, they had found a way to screen out, but "now we have to find a way to screen in." The workers will be employed in basic skills such as electrical wiring, and will receive vestibule training. A recruiter who is able to relate to people in the hard-core communities has been retained and has had measurable success in getting prospective workers. Most of those hired are men. The recruiter will consider hiring those with medical and mental handicaps, those with criminal records or who have had some contact with the law except those with drug addiction records who would need careful assignment. Persons hired in the Grumman recruiting program will also be given basic literacy training and promotional opportunities based upon their skills and aptitudes.

In addition to his work at Grumman, Mr. Van Putten has been chairman of the Nassau-Suffolk National Alliance of Businessmen, and in this role has worked cooperatively with the New York State Employment Service (NYSES) and various community agencies including the National Association for the Advancement of Colored People (NAACP) and the Congress for Racial Equality (CORE). He found that the most effective working relationship was with CORE.

Another area where attention must be given to the unemployed and underemployed according to Mr. Van Putten, is the Wyandanch-Amityville area. He indicated that the Nassau-Suffolk National Alliance of Businessmen has a contract with the government to subsidize certain costs in administering an employment program. The group will utilize an outside consultant to assist in developing the program.

Mr. Van Putten indicated that another employment program was set up through the Suffolk County Human Resources Commission. A mobile unit was set up which was fully manned by the Commission with the exception of an interviewer. Eighteen of 78 persons interviewed were hired at Grumman.

Mr. Van Putten also indicated that Kollsman Instruments and the Long Island Lighting Company have been pioneers in reaching the hard-core unemployed.

General comments made by Mr. Van Putten during the interview were on the subjects of transportation, vocational schools, and communication with the hard core:

- Transportation has been used as a "scare" word to keep people out of jobs. In some instances he said, even when buses were put into service, the buses were not used. Many workers wanted to use a car pool because it was the most reliable. Most people preferred to drive their own cars.

- More vocational schools should relate their training to the needs of Grumman Aircraft and other industries. The exceptions are the Brooklyn Technical High School and Sewanhaka in Floral Park.

- The hard core are not reached by television, radio or newspapers. They feel that "this is the white guy's propaganda; it does not really mean me." In terms of community contact, the most significant area where hard-core unemployed are most likely to be known is in the schools. However, Mr. Van Putten has had little contact with the Board of Cooperative Educational Services (BOCES) and its function of identifying and working with families who are hard core to provide them with the services they need.

The foregoing, based on discussions with Mr. Van Putten, is a late start in the right direction, but it may be jeopardized by an economic downturn. Michael Harrington, writing in The Center Magazine, states:

> "If there is an economic downturn, the new activism of the poor — those tentative essays in hope which we have will be turned into despair, most of it passive, some of it dangerously angry.
>
> If the talk of 'trading off' a little unemployment in return for increased price stability becomes more than talk, and joblessness, as a result, rises to five or six percent, the extremely modest employment gains of our recent efforts would be abolished and the nation would return to the status quo ante, or worse. Up to now, when the private sector had hired marginal

> workers, even with federal inducements, it has done so only because a relatively tight labor market had made it economically feasible to take a few, a very few, risks on the hard core jobless; the moment the official unemployment rate hits five percent it will become economically imperative for corporations to fire those men and women.
>
> This would drastically affect the quality of life in the other America. It would deprive the poor of part of their already meager economic resources...and most terrible of all, it would teach those who had dared to be hopeful that America was only kidding and that cynicism is the better part of valor."

-Michael Harrington
"The Other America Re-Visited," The Center Magazine

The Region II Manpower, Labor and Industry Task Force recommendations follow.

WE RECOMMEND THAT COUNSELORS AND OTHERS RESPONSIBLE FOR PLACEMENT SHOULD BE AWARE OF CHANGING TECHNOLOGIES AND JOB REQUIREMENTS, MAINTAIN CLOSER, MORE MEANINGFUL WORK RELATIONSHIPS WITH EMPLOYERS TO ACHIEVE DESIRED INTERACTION BETWEEN INDUSTRY'S CRUCIAL NEED FOR WORKERS, AND BE AWARE OF THE URGENT NEED FOR TRAINING PROGRAMS FOR THE UNEMPLOYED AND UNDEREMPLOYED. PRIORITY: URGENT

WE RECOMMEND THAT REGIONAL COORDINATORS BE APPOINTED TO IMPLEMENT THE PLACEMENT OF THE DISABLED IN STATE, COUNTY AND LOCAL CIVIL SERVICE JOBS. PRIORITY: URGENT

Practice, not policy, within municipal and state civil service discourages employment of the handicapped. There is evidence that the private business sector has taken more initiative in employment of the handicapped than has the public sector.

WE RECOMMEND THE ADDITION OF MORE PLACEMENT STAFF TO CONTACT EMPLOYERS TO INCREASE PLACEMENT OF THE HANDICAPPED. PRIORITY: URGENT

In the area of job placements many employers have indicated their willingness to hire handicapped people if contracted by the agencies involved.

WE RECOMMEND THAT MORE EMPLOYERS SHOULD UTILIZE TECHNOLOGICAL AND OTHER AVAILABLE SERVICES NEEDED TO HIRE THE DISADVANTAGED AND DISABLED. PRIORITY: ESSENTIAL

Recruitment personnel should be able to effectively relate and communicate with the disadvantaged and disabled.

AUTOMATION SHOULD BE APPLIED TO THE SELECTION OF TRAINING FOR HANDICAPPED INDIVIDUALS. THE PROCESS SHOULD INCLUDE USING THE JOB ANALYSIS SYSTEM WHEREBY:

- THE PHYSICAL DEMANDS OF NUMEROUS JOBS CAN BE DEFINED AND PUNCHED OUT BY KEY PUNCH OPERATORS AND DISTRIBUTED THROUGHOUT THE AREAS WHERE TRAINING AND JOB SELECTION ARE DONE. THIS WOULD PROVIDE A TREMENDOUS RESOURCE FOR JOB SELECTION AND TRAINING BASED UPON PHYSICAL DEMANDS.

- THE PHYSICAL CAPABILITIES FOR EACH INDIVIDUAL HANDICAPPED PERSON COULD SIMILARLY BE PUT ON A PERMANENT CARD. THE COPY CAN BE GIVEN TO THE HANDICAPPED INDIVIDUAL AND ONE OR MORE COPIES CAN BE RETAINED AT THE AGENCY OR AT A SERVICE BUREAU CENTER.

- AT ANY GIVEN TIME, THE PERMANENT PHYSICAL CAPABILITIES CARD OF THE HANDICAPPED PERSON COULD BE INSERTED INTO A COMPUTER, A SERVICE CENTER OR ANY SUITABLE PLACE WHICH WOULD, AT ONE AND THE SAME TIME, REJECT THOSE AREAS OF WORK WHICH THE CLIENT CANNOT PHYSICALLY HANDLE AND INDICATE THOSE AREAS OF TRAINING AND WORK THAT THE HANDICAPPED INDIVIDUAL COULD HANDLE.

- THE CLIENT COULD BE GIVEN INFORMATION ON THE AREAS OF WORK THAT INTERESTED HIM FROM THE SELECTION OF THOSE JOBS WHOSE PHYSICAL DEMANDS HE COULD MEET. PRIORITY: ESSENTIAL.

We have been living in the age of automation for almost two decades. The adoption of computers to many services of our daily lives is entering new and surprising areas; they save untold hours of men laboring with manual mathematical equations for solutions within the competence of a relatively few people.

At the present time, the selection of training for handicapped individuals is, in many cases, a hit and miss affair. Hopefully, the client is given information on which to base a decision for training, in addition to the client's own resources which may be limited to the Occupational Outlook Handbook and his limited areas of comparison or knowledge or firsthand experiences in the labor market. The best available information indicates that this limited area of resources can be considerably enhanced by the application of automation assistance to the selection of appropriate training.

The advantages of using the job analysis system include:

- Enlarging the area of positions for training handicapped individuals while at the same time providing industry with needed workers.
- Considerably reducing the number of man-hours required for selection of training and job placement in a tight labor market when workers in many fields are in desperately short supply.
- Benefits from utilizing all available manpower to advance the general welfare and productivity.
- Supplying employers with needed manpower in a most adventageous way in shorter periods of time.
- Providing industry with a stable labor force of highly selected manpower and reducing the need for duplication of personnel services.
- The opportunity to set up, nationally, a vast system of labor training and placement duplicated in as many labor areas as necessary.
- The option to respond to job changes in demand or capacities to jobs that disappear from the labor market or jobs created by new businesses.
- The timeliness of the greater need to know job requirements especially because of the amputee rate of returning Vietnam veterans, a rate that is 20 percent higher than it was with other war veterans.
- Establishing job resource centers in the nine federal regions of the United States in the state, or by other geographical or governmental units.
- The opportunity to maintain industry and permanent archives for the handicapped.
- Substantially reducing the amount of time required for evaluation and recording statistical analysis, controls and reporting.

WE RECOMMEND THAT PROGRAMS FOR TRAINING THE DISABLED AND DISADVANTAGED SHOULD BE MORE REALISTICALLY RELATED TO INDUSTRIAL AND JOB DEMANDS: EQUIPMENT AND TRAINING ENVIRONMENT MUST REFLECT THESE DEMANDS. PRIORITY: URGENT

THERE NEEDS TO BE A THOROUGH REEXAMINATION OF THE PRESENT FEDERAL, STATE AND LOCAL CIVIL SERVICE REQUIREMENTS FOR EMPLOYMENT OF THE HANDICAPPED. THERE SHOULD BE MORE RELAXATION IN THE REQUIREMENTS OF CIVIL SERVICE EXAMINATIONS WHEN THE BLIND OR DEAF PERSONS ARE INVOLVED. PRIORITY: ESSENTIAL AND SHORT-TERM

Where communicative skills are involved in the taking of examinations, allowance should be made at all levels for the blind and deaf if they otherwise qualify for the position. Parts of the written examination could be waived in the case of a blind or deaf person who has achieved certification from a reputable training program such as exists in computer work.

In addition, at all levels of government there should be more effective internal coordination of Civil Service appointments of handicapped individuals so that government agencies can more readily take advantage of this manpower reservoir. What is needed is more orientation and education within the government agencies as to the availability and feasibility of employing handicapped individuals in Civil Service positions. Government agencies should encourage their employers to hire the handicapped and to give them a chance under the same probationary conditions as is used for all employees. Handicapped groups, especially the blind and deaf or the more severe disability groups, should be adjudged as qualified for Civil Service positions based on their training, past experience and tested aptitude on competitive examinations for which they may presently be penalized because of their handicap. Also, more weight should be given to the recommendations of state rehabilitation agencies in certifying qualified individuals for specific Civil Service positions.

SINCE CIVIL SERVICE EMPLOYMENT OPPORTUNITIES ARE LIMITED TO OFFENDERS, IT IS RECOMMENDED THAT THIS PRACTICE BE REVIEWED AND CHANGED TO PROVIDE JOB OPPORTUNITIES FOR OFFENDERS. PRIORITY: URGENT

IN ORDER TO ASSIST IN MEETING THE MANPOWER SHORTAGE IN FUTURE PLANNING, CONSIDERATION SHOULD BE GIVEN TO LOOKING FOR WORKERS FOR THE REHABILITATION FIELD AT THE ASSOCIATE ARTS LEVEL.(TWO YEAR OR JUNIOR COLLEGE).

THESE STUDENTS COULD BE CONSIDERED FOR PARAPROFESSIONAL JOBS IN STATE OR PRIVATE AGENCIES. THEIR WORK EXPERIENCE SHOULD BE CONSIDERED FOR COLLEGE CREDIT, AND ACCREDITATION ISSUED FOR THE PARAPROFESSIONAL FIELD.* PRIORITY: ESSENTIAL

THE JOB DUTIES OF REHABILITATION COUNSELORS SHOULD BE ANALYZED TO DEVELOP CAREER LADDERS TO MEET MANPOWER NEEDS.* PRIORITY: URGENT

WE RECOMMEND THAT LABOR GROUPS SHOULD BE ENCOURAGED TO RECRUIT THE DISADVANTAGED AND/OR DISABLED FOR LABOR APPRENTICESHIPS AS WELL AS OTHER JOBS. PRIORITY: URGENT

***See Appendix A for two examples of Career Ladder positions, the social service aide and the counselor associate, which are used by the California State Personnel Board.**

ESTIMATED TARGET POPULATION FISCAL YEAR 1969, DIVISION OF EMPLOYMENT ADMINISTRATIVE DISTRICTS AND SELECTED AREAS NEW YORK STATE*

Area	Civilian Labor Force, April 1960		Unemployment Annual Average 1967	Families With 1959 Income Below $3000		
	Total (1)	Unemployed (2)	(3)	Total (4)	White (5)	Nonwhite (6)
New York State	6,958,000	359,000	306,000	600,000	509,000	92,000
Percent Distribution by area						
Eastern Area	27.2	24.1	28.5	23.3	25.6	10.6
Long Island District	10.2	5.9	11.6	5.8	6.2	3.4
Parts of New York - S.M.S.A.						
Nassau	7.0	3.3	6.4	3.0	3.2	1.7
Suffolk	3.2	2.7	5.2	2.8	3.0	1.7
Suburban District	6.8	4.7	5.5	4.7	4.8	4.3
Parts of New York - S.M.S.A.						
Westchester	4.9	3.0	3.7	2.8	2.7	3.4
Rockland	0.7	0.5	0.7	0.4	0.5	0.2
Rest of District	1.2	1.3	1.1	1.4	1.6	0.7

ESTIMATED TARGET POPULATION FISCAL YEAR 1969, DIVISION OF EMPLOYMENT ADMINISTRATIVE DISTRICTS AND SELECTED AREAS NEW YORK STATE*
Cont'd.

Area	Persons 25 Years of Age and Over With Education Attainment		Population			
	Less than 9 years (7)	Between 9 & 11 years (8)	Total 1967 (9)	Nonwhite 1960 (10)	Allocation Factor (11)	Target Population (in thousands) (12)
New York State	3,876,000	2,111,000	18,042,000	1,491,000	xxx	1,160,000
Percent Distribution by area						
Eastern Area	24.3	28.1	31.5	13.6	23.7	274.9
Long Island District	7.8	11.2	13.4	5.2	8.1	94.0
Parts of New York - S.M.S.A.						
Nassau	4.5	7.0	8.0	2.8	4.7	54.5
Suffolk	3.2	4.2	5.4	2.3	3.4	39.4
Suburban District	5.5	6.2	7.3	5.3	5.5	63.8
Parts of New York - S.M.S.A.						
Westchester	3.5	4.2	4.8	4.2	3.7	42.9
Rockland	0.7	0.7	1.1	0.5	0.6	7.0
Rest of District	1.3	1.3	1.4	0.7	1.2	13.9

*Based on allocation factor determined by area's relative share of state total for 10 indicators.

REGION II

TOTAL NUMBER OF JOBS (a), BY INDUSTRY, ESTIMATED 1960 AND 1965 AND PROJECTED 1970 AND 1975, WESTCHESTER-ROCKLAND AREA
(in thousands)

INDUSTRY	1960	1965	1970	1975
Total Employment	344.3	389.9	462.8	528.5
Manufacturing	82.2	90.2	103.2	113.9
Nonmanufacturing	262.1	299.7	359.6	414.6
Transportation, communication and public utilities	21.6	23.2	25.9	29.8
Wholesale and retail trade	73.3	83.3	99.3	115.7
Finance, insurance and real estate	15.9	18.3	21.9	24.7
Services	109.1	129.5	158.3	186.2
Public administration	13.3	15.7	19.3	20.0
State and local	10.1	11.2	14.1	14.3

REGION II

TOTAL NUMBER OF JOBS (a), BY INDUSTRY, ESTIMATED 1960 AND 1965 AND PROJECTED 1970 AND 1975, NASSAU-SUFFOLK AREA
(in thousands)

INDUSTRY	1960	1965	1970	1975
Total Employment	587.5	717.8	908.2	1,081.0
Manufacturing	130.8	141.6	171.1	187.6
Nonmanufacturing	456.7	576.2	737.1	893.4
Contract construction	51.7	56.7	71.1	83.4
Transportation, communication and public utilities	21.7	33.1	43.0	51.7
Wholesale and retail trade	139.4	182.6	222.7	270.5
Finance, insurance and real estate	24.0	31.7	41.4	50.7
Services	183.4	235.8	309.4	371.2
Public Administration	19.3	26.4	40.1	55.9
Local	10.7	15.2	26.8	41.0

Source: Manpower Directions, New York State, 1965-1975, Volume II, New York State Department of Labor, Division of Research and Statistics.

FINDINGS AND RECOMMENDATIONS: TRANSPORTATION AND ARCHITECTURAL BARRIERS

Transportation

Transportation is the most serious problem faced by the disabled. In the four metropolitan counties of Region II—Nassau, Suffolk, Rockland and Westchester--the problems are critical. Most railroad stations in Long Island and Westchester are inaccessible to wheelchair users and other handicapped. Buses are similarly lacking in needed ingress and egress facilities for the handicapped. And existing special transportation services for the handicapped are so inadequate that denial of available services to clients may hinge on this fact alone.

When we consider transportation for the handicapped, we have to be aware of the rising number of paraplegics due to traffic accidents, the war veterans who must use wheelchairs, the population affected by birth defects requiring the use of crutches, braces, wheelchairs and prostheses, and the population which is affected by diseases such as arthritis, cerebral palsy, muscular dystrophy and multiple sclerosis, as well as strokes and amputations.

Rapidly growing Nassau County is not only the home of more commuters than any other New York State county, but it is an important center of industry. Bounded on the north and south by water, its outward commuting pattern is almost entirely into New York City, drawing 192,000 of Nassau County's 209,000 outward commuters. However, 55,000 come from the city to Nassau County, especially to work in aircraft and precision electronics, manufacturing, printing and publishing. Nassau County also draws 32,000 commuters from Suffolk County.

The second largest group of working commuters resides in Westchester County. More workers commute from Westchester County than from any other county in New York State except Nassau. Over 100,000 workers leave the county daily, with New York City receiving 90 percent. In return, Westchester industries attract some 40,000 workers, including 28,000 from New York City. It is the principal destination for commuters from Putnam County. General Motors at Tarrytown, Otis Elevator at Yonkers, and a number of executive offices and research establishments provide employment opportunities.

Suffolk County, which makes up the eastern three-fourths of Long Island, is surrounded on three sides by water, so commuters go west only. The location of Suffolk's population centers on the southern shore adds to the difficulty of commuting northward toward Connecticut and upstate New York. Almost as many Suffolk commuters travel to Nassau County as to New York City, over 30,000 to each location. Although Suffolk County's aircraft and instruments plants and giant hospitals, which are the major employers, draw some 20,000 commuters, this is less than a third of those who commute out of the county.

Rockland County has the smallest percentage of its resident workers of any of the four suburban New York Metropolitan Area counties going out of the county to work. More than half of its commuters go to New York City, and a tenth to Westchester County, with little traffic the other way. Almost all the remainder go to New Jersey, from where an equally large group comes, many to work at American Cyanamid's Lederle Laboratories at Pearl River. About 1,000 workers commute to Rockland from Orange County and another 1,000 from New York City.*

Based on the commuter travel patterns, the present emphasis for transportation service is obviously into and out of New York City, leaving local transportation needs largely unmet.

In spite of the public wealth invested in providing independent living to large groups of handicapped, inadequate or nonexistent transportation as well as architectural barriers nullify the independent living gains and prevent the handicapped from enjoying productive and useful lives as workers, or as independent family workers or homemakers.

Architectural Barriers**

Generally, the physical design of buildings and facilities the handicapped must use is the single most important barrier to employment. In every community, virtually all of the buildings and facilities most commonly used by the public have features that bar the handicapped. Yet, new facilities which are built and equipped to accommodate the handicapped cost little or no more to construct than buildings designed

---

*Commuting from County to County in New York State, New York State Department of Commerce, 1965.

**Design For All Americans, U.S. Department of Health, Education and Welfare, Rehabilitation Services Administration, Social and Rehabilitation Service, Report of the National Commission on Architectural Barriers to Rehabilitation of the Handicapped only for the able bodied. Also, many old buildings could have some barriers removed at nominal cost. The most common causes of inaccessibility are due entirely to a failure to think of the needs of the handicapped at the design and planning stage of a building.

Builders should keep in mind that a fresh reservoir of competent employees could be tapped or new customers obtained by adding accessibility features such as: hand rails, a ground-level main entrance or ramp, steps that are rounded instead of squared at the edges, doors that open automatically, raised letters and numbers on doors in elevators so that the blind can read them, danger signals equipped with light as well as sound so that the deaf will be warned, an open booth with a low-placed telephone, one or more wide toilet stalls with grab rails, and nonslip flooring.

The National Commission on Architectural Barriers has recommended the following:

1. Enactment of federal legislation requiring that all new public buildings and facilities which are intended for use by the public must be designed to accommodate the elderly and the handicapped if any federal funds are used in their construction.
2. Issuance of an executive order to apply accessibility standards to new construction and directing all federal agencies to plan and budget for feasible changes in their existing buildings and facilities.
3. Enactment or revision of state legislation, including strong enforcement provisions, to require that state and local buildings constructed with public funds meet accessibility standards.
4. Revision of all building codes so that industries, shops and other privately owned structures used by the public will be built for accessibility in the future so that when existing buildings are renovated, feasible improvements in accessibility will be made.
5. Assignment of responsibility and resources to specific units of federal, state and local governments to administer the accessibility legislation, to conduct and/or support research and demonstrations, and to work with voluntary, professional, business and industrial organizations to the end that all buildings and facilities used by the people of every community will be readily accessible to elderly and handicapped people.
6. Expansion of public and privately supported education and information programs so that no longer, merely through thoughtlessness, will millions of citizens be unable to use buildings, parks and other facilities.

Recommendations

WE RECOMMEND THAT THE WESTCHESTER COUNTY ARCHITECTURAL BARRIERS COMMITTEE BE EXPANDED TO INCLUDE REPRESENTATIVES FROM ALL APPROPRIATE PUBLIC AND VOLUNTARY AGENCIES. PRIORITY: DESIRABLE

WE RECOMMEND THAT EVERY AGENCY AND FACILITY PROVIDING REHABILITATION SERVICES SHOULD BE ASKED TO LIST THE NATURE AND DEGREE OF THE TRANSPORTATION PROBLEM OF EVERY CLIENT THEY SERVE WHO ENCOUNTERS DIFFICULTIES IN GETTING TO THE POINT OF SERVICE. PRIORITY: URGENT

> Agencies and facilities should get together, particularly those in the same area, to define common problems and propose transportation solutions. Then a county-wide conference should be considered and include representatives of health and social services, public and private. Concerted attention must also be given to resolving some of the transportation problems faced by clients in their pre-rehabilitation and rehabilitation programs. In Suffolk County this is a mammoth undertaking which seems to defy resolution. Perhaps it may be necessary to say that no new or expanded rehabilitation programs should be undertaken until it is clear that transportation for clients will not be a major obstacle.

WE RECOMMEND THAT AS PART OF ANY OVERALL TRANSPORTATION SURVEY, A GROUP OF INDIVIDUALS WITH SPECIAL KNOWLEDGE OF TRANSPORTATION SHOULD BE ASKED TO DO A TRANSPORTATION NEEDS STUDY AS IT RELATES TO HEALTH AND SOCIAL SERVICES. PRIORITY: ESSENTIAL

> A sampling technique should be used to find, for example, how close public transportation comes to rehabilitation facilities. Our survey reveals that patients' transportation problems are usually underestimated, and that resolutions are often on a day-to-day basis with each facility trying to solve its own problem and leaving the development of coordinated transportation to someone else.

NO MATTER HOW WELL DEVELOPED PUBLIC TRANSPORTATION BECOMES, THERE WOULD SEEM TO BE A CONTINUING NEED FOR SPECIAL TRANSPORTATION SERVICES FOR THE SEVERELY HANDICAPPED AND PROBLEM CASES. PRIORITY: ESSENTIAL

In some instances rehabilitation personnel or teams may have to seriously consider traveling to various client locations. It is imperative to any planning for future facilities and services that transportation problems be considered and resolved in the overall plan for providing service.

IT IS RECOMMENDED THAT PRIMARY AND SECONDARY REHABILITATION CENTERS, STATE HOSPITALS AND SCHOOLS, AND SHELTERED WORKSHOPS BE ENCOURAGED TO PROVIDE TRANSPORTATION FOR OUT-PATIENTS NOT CAPABLE OF USING PUBLIC TRANSPORTATION OR FOR WHOM PUBLIC TRANSPORTATION IS NOT AVAILABLE; THAT THIS ENCOURAGEMENT BE REINFORCED BY PROVISIONS FOR SUCH SERVICE BEING INCORPORATED INTO AVAILABLE STATE AND FEDERAL GRANTS. PRIORITY: URGENT

Transportation is a major problem in the delivery of services. If facilities or agencies serving large groups of clients had their own buses, for example, many more people could be provided with necessary services. The physically disabled in all but the larger cities of the state have difficulty in using existing rehabilitation facilities because of the scarcity of public transportation. Or if transportation is available, it is many times physically impossible for the handicapped to utilize this service.

LOCAL COUNTY GOVERNMENT MUST BE ENCOURAGED TO DEVELOP AND PROVIDE BETTER AND MORE EFFICIENT PUBLIC TRANSPORTATION FACILITIES IN THE COUNTY WITH THE LONG-RANGE PLANNING OBJECTIVES IN KEEPING WITH POPULATION INCREASES. PRIORITY: ESSENTIAL

Round trip transportation facilities to New York City are available in some areas, but transportation from New York City and other directions is inadequate. Transportation facilities are especially inadequate in the Region II counties as they pertain to travel by handicapped persons.

UNTIL ADEQUATE TRANSPORTATION FACILITIES BECOME AVAILABLE, THERE SHOULD BE JOINT EFFORT BY ALL PUBLIC AND PRIVATE AGENCIES TO DEVELOP MUTUAL AND COORDINATED PLANS TO TRANSPORT HANDICAPPED INDIVIDUALS WITHIN EACH COUNTY SO THAT THE AGENCIES MIGHT TAKE ADVANTAGE OF THE DIVERSITY OF AVAILABLE SERVICE. PRIORITY: ESSENTIAL AND LONG-TERM

This might be done by the development of a bus or limousine service or by developing mobile facilities for evaluation, testing and treatment or even for sheltered employment. The lack of adequate transportation contributes to the immobility of the handicapped and makes it difficult for them to take advantage of evaluation, training or placement.

WE RECOMMEND THAT SCHOOL BUSES BE UTILIZED TO TRANSPORT THE HANDICAPPED AND THAT WAYS TO UTILIZE THIS VALUABLE RESOURCE BE DEVELOPED AND IMPLEMENTED. PRIORITY: URGENT

Since school buses are used for relatively short periods of time in the morning and in the afternoon and then parked for the rest of the day, this available community resource should be used for transporting the handicapped.

WE RECOMMEND THAT A COUNTYWIDE SYSTEM BE ESTABLISHED FOR TRANSPORTING SEVERELY DISABLED PERSONS TO AND FROM WORK AND/OR TO AND FROM REHABILITATION TREATMENT FACILITIES. HIGH PRIORITY

The recommendation of the workshops study completed by the Westchester County Council of Social Agencies was the need to develop in Westchester County comprehensive rehabilitation center programs which would serve multiple disability groups, and that the location of such centers should depend upon population density, transportation problems and available resources. Highly developed services cannot be developed at every street corner, but the development of a sound transportation program to bring the disabled to centrally located facilities is essential in view of the personnel and other shortages faced by rehabilitation agencies.

THERE IS A NEED FOR IMPROVED AND MORE EXTENSIVE TRANSPORTATION FOR THE HANDICAPPED. WE SUPPORT THE PILOT PROJECT OF "WHEELS FOR THE HANDICAPPED." HIGH PRIORITY

Training handicapped and indigenous workers to function in needed transportation work will be the first work experience for many and their first work contribution to the community. (The pilot project "Wheels for Westchester" is discussed in detail in the Disability Section, The Disadvantaged - Social and Economic Disability, p. 184.)

FINDINGS AND RECOMMENDATIONS: LEGISLATIVE CHANGES

Recent legislation which extends programs and coverage in vocational rehabilitation, e.g., Public Laws 89-333 and 90-391, project new approaches to rehabilitation. Although these laws are designed to extend rehabilitation into new areas of service, the Region II Advisory Committee feels that existing conditions in some areas are not covered such as the lack of subsidies and guaranteed income, and social security requirements for maximum income that tend to limit the productivity of the handicapped worker. The committee also feels that existing Medicaid coverage does not provide enough protection for the retarded, nor does it provide orthodontia, plastic surgery and speech therapy for those needing such services, and finally, that employers should be mandated to hire the handicapped and have a set standard for the number of handicapped to be employed. This would also apply to the disadvantaged or hard core unemployed.

The advisory committee finds the federal formula for construction grants a barrier to construction. The committee asks for a revised formula to encourage new construction of facilities.

The recommendations which follow represent careful thought and evaluation of existing problems and barriers. With probity and courage, new approaches, expanded coverage and bold concepts are presented with the expectation of implementation. Page references noted after each recommendation refer to a preceeding disability or other section of the report where the recommendations and rationale originally appeared.

MEDICAID: IT IS RECOMMENDED THAT MEDICAID BE GIVEN TO ALL MENTALLY RETARDED OVER AND ABOVE GUARANTEED INCOME AND THAT MEDICAID PROVISIONS BE LIBERALIZED TO INCLUDE REHABILITATION SERVICES SUCH AS PLASTIC SURGERY, ORTHODONTAL WORK, SPEECH THERAPY AND OTHER THERAPIES. PRIORITY: DESIRABLE

SUBSIDIES TO INDIVIDUALS:

MARGINALLY RETARDED: WE RECOMMEND THAT A GUARANTEED INCOME BE GIVEN TO THE MENTALLY RETARDED WORKER OF NOT LESS THAN THE MINIMUM WAGE IF HE IS SINGLE, AND THAT THIS INCOME BE INCREASED IN PROPORTION TO THE SIZE OF THE FAMILY. THE GUARANTEED INCOME TABLE SHOULD BE RELEVANT TO THE COST OF LIVING INDEX IN THE AREA IN WHICH HE LIVES. PRIORITY: URGENT

SEVERELY RETARDED: WE RECOMMEND THAT EVERY SHELTERED EMPLOYEE BE GIVEN A GUARANTEED INCOME OF NOT LESS THAN THE MINIMUM WAGE IN EFFECT WHERE HE LIVES. PRIORITY: URGENT

PROFOUNDLY RETARDED: WE RECOMMEND THAT THE MINIMUM INCOME OF $3000 BE PAID TO THEM UNDER THE PROVISIONS OF THE AID TO THE TOTALLY DISABLED OF THE SOCIAL SECURITY ACT. WITHIN THIS FRAME OF REFERENCE WE ALSO RECOMMEND THAT THE AID TO THE TOTALLY DISABLED PROGRAM BE REMOVED FROM THE WELFARE OR SOCIAL SERVICE DEPARTMENTS, AND THAT THE BENEFITS BE PAID DIRECTLY TO THE CLIENT BY THE SOCIAL SECURITY ADMINISTRATION IN THE SAME WAY THAT RETIREMENT AND SURVIVOR BENEFITS ARE PAID. PRIORITY: URGENT (See "Mental Retardation" p.193)

EMPLOYMENT PRACTICES: WE RECOMMEND THAT A LAW BE ENACTED TO MANDATE INDUSTRY TO HIRE FIVE PERCENT OF ITS WORK FORCE FROM THE HANDICAPPED AND DISADVANTAGED POPULATION WITH THE SINGLE EXCEPTION THAT WHERE INDUSTRY DOES NOT MEET THIS REQUIREMENT, THEY BE MANDATED TO CONTRACT FIVE PERCENT OF THEIR PRODUCTION TO SHELTERED WORKSHOPS EMPLOYING THE HANDICAPPED. PRIORITY: ESSENTIAL (See "Mental Retardation" p. 194)

SUBSIDIES TO VOLUNTARY AGENCIES: WE RECOMMEND THAT A PER CAPITA SUBSIDY BE GUARANTEED TO EVERY AGENCY OPERATING A VOCATIONAL TRAINING CENTER AND SHELTERED WORKSHOP FOR THE MENTALLY RETARDED. PRIORITY: URGENT (See "Mental Retardation" p.194)

SUBSIDIES AND GUARANTEED WAGE: WE RECOMMEND THAT THE GOVERNMENT, BE IT STATE OR FEDERAL OR BOTH, PROVIDE A WAGE SUBSIDY FOR CLIENTS IN THE SHELTERED WORKSHOP IN ORDER TO PROVIDE THEM WITH THE MINIMUM WAGE. PRIORITY: ESSENTIAL (See "Communications Impairments" p.172)

SOCIAL SECURITY AND VOCATIONAL REHABILITATION: IT IS RECOMMENDED THAT THE SOCIAL SECURITY DISABILITY EARNINGS CEILING OF $1,680 SHOULD BE RAISED OR REMOVED FOR ALL DISABLED PERSONS WHO HAVE BEEN CERTIFIED AS BEING CAPABLE ONLY OF WORKING IN THE SPECIAL WORKSHOP. PRIORITY: DESIRABLE (See "Communications Impairments" p. 172)

TRANSPORTATION: WE RECOMMEND THAT THE WORKER'S INCOME BE SUPPLEMENTED WITH A TRANSPORTATION ALLOWANCE UP TO 90 PERCENT OF THE COST. PRIORITY: URGENT (See "Mental Retardation" p.194)

PACKAGE SERVICES: WE RECOMMEND THAT WHEREVER POSSIBLE, SERVICES IN BLIND AGENCIES BE PURCHASED ON A PACKAGE BASIS WHICH WOULD INCLUDE THE MAJOR SERVICES SUPPLEMENTED BY SUCH SERVICES AS CASEWORK, PSYCHOLOGICAL SERVICES AND REMEDIAL SERVICE TO TRAINING AT A FEE TO COVER ACTUAL COSTS OF SUCH A GROUP OF SERVICES. PRIORITY: DESIRABLE (See "Communications Impairments" p.172)

INDEPENDENT LIVING SERVICES: IT IS RECOMMENDED THAT THE FEDERAL AND STATE VOCATIONAL REHABILITATION LAWS BE AMENDED TO ALLOW THE PROVISION OF REHABILITATION SERVICES TO THE AGED FOR INDEPENDENT LIVING, EVEN WHERE THERE IS NO VOCATIONAL OR HOMEMAKING OBJECTIVE. PRIORITY: DESIRABLE

> These services are needed especially with the aged blind where communicative services, mobility services, etc. would allow the individual to function more independently and with greater satisfaction. As the handicapped lives longer, there is greater need for rehabilitation services for independent living, including personal and social adjustment for the older handicapped individual.

HOMEBOUND PROGRAMS: THERE IS A NEED TO DEVELOP HOMEBOUND PROGRAMS FOR THE AGED HANDICAPPED INDIVIDUAL. PRIORITY: HIGH

> Although the need is great, there is very little homebound work activity available for the aged blind or hard of hearing.

VOCATIONAL TRAINING CENTERS AND SHELTERED WORKSHOP CONSTRUCTION FUNDS: WE RECOMMEND THAT THE FEDERAL FORMULA WHICH PROVIDES CONSTRUCTION FUNDS TO BUILD VOCATIONAL TRAINING CENTERS AND SHELTERED WORKSHOPS BE REVISED SO THAT THE FEDERAL SHARE WILL BE AT LEAST 60 PERCENT, THE STATE SHARE 30 PERCENT, AND THE VOLUNTARY AGENCY SHARE 10 PERCENT. IN ADDITION, THERE SHOULD BE A PROVISION WHICH ALLOWS THE VOLUNTARY AGENCY TO BORROW MORTGAGE FUNDS FROM THE STATE AT LOW INTEREST RATES. IN NEW YORK THIS CAN BE DONE THROUGH THE HOUSING FINANCE CORPORATION AND/OR THE MENTAL HYGIENE FACILITIES IMPROVEMENT FUND. PRIORITY: ESSENTIAL (See "Mental Retardation" p.195)

OCCUPATIONAL DAY CENTERS FOR ADULTS: WE RECOMMEND THAT THE SAME PROVISION FOR CONSTRUCTION OF VOCATIONAL TRAINING CENTERS AND SHELTERED WORKSHOPS BE APPLICABLE TO OCCUPATIONAL DAY CENTERS, WITHIN THE FRAMEWORK OF VOCATIONAL REHABILITATION. PRIORITY: ESSENTIAL (See "Mental Retardation" p.195)

BIBLIOGRAPHY

Annual Report, 1966, Suffolk County Department of Social Services, Hauppauge, N. Y.

Annual Report: Westchester County Transit Board, 1966, Workers Planning Committee, White Plains, N.Y.

Annual Report, 1967, Rockland County Department of Social Services

Annual Report of the County Executive, 1966, Suffolk County, Hauppauge, N.Y.

Avnet, Helen H., *Physician Service Patterns and Illness Rates*, A Research Report on Medical Data Retrieved from Insurance Records Undertaken by Group Health Insurance, Inc., New York, 1967

Basic Statistics for Counties and Metropolitan Areas of New York State, New York State Department of Commerce, Research Bulletin No. 17, Albany, N. Y., January 1967

Bridge, Franklin, M., *The 1970 Census: A Look Ahead*, New York State Office of Local Government

Business and the Urban Crisis, McGraw-Hill, New York, N.Y., 1968

Commuting From County to County in New York State, New York State Department of Commerce, Research Bulletin No. 11, Albany, N. Y., August 1968

County Catalog, 1964, Suffolk County Department of Planning, Hauppauge, N. Y.

Demographic Projections for New York State Counties to 2020 A.D., New York State Office of Planning Coordination, Albany, N. Y., June 1968

Design for All Americans, Rehabilitation Services Administration, Social and Rehabilitation Service, U.S. Government Printing Office, Washington, D.C., December 1967

DiMichael, Salvatore G., ed., *New Vocational Pathways for the Mentally Retarded*, American Personnel and Guidance Association, Washington, D.C., 1966

Directory of Community Services, Westchester County Council of Social Agencies, White Plains, N.Y., 1965

Evaluation and Benefit Cost Relationships of Manpower Training Programs in New York State, New York State Department of Labor, Albany, N.Y., October 1967

Facts in Brief, New York State Education Department, Division of Vocational Rehabilitation, Albany, N.Y., No. 1, June 1965

Facts on the Major Killing and Crippling Diseases in the United States Today, The National Health Education Committee, New York, N.Y., 1966

Fenton, Elaine R., *Directory of Services for the Hearing and Speech Handicapped*, N. J. Leigh Foundation, New York, N.Y., 1968

First Year's Activities in Selected Economically Depressed Areas of California, Sacramento, Cal., June 1967

Furlong, William Barry, "A New Factory Product: Instant Education," *New York Times Magazine*, December 1, 1968

"Guides to the Evaluation of Permanent Impairment, Mental Illness," *The Journal of the American Medical* Association, Vol. 198, December 1966

Jacobsen, Marilyn-Lu, *Health Careers Project Report*, Suffolk Community College, Selden, N.Y., June 1968

Haber, Lawrence D., "Identifying the Disabled: Concepts and Methods in the Measurement of Disability," *Social Security Bulletin*, December 1967

Handbook of Labor Statistics, U.S. Department of Labor, Bureau of Labor Statistics, U.S. Government Printing Office, Washington, D.C.

Harrington, Michael, "The Other America Revisited," *The Center Magazine*, Vol. II, No. 1, January 1969

LaVerne, Thomas, *The Manpower Paradox-Workers Without Jobs; Jobs Without Workers*, Report of the New York State Senate Labor and Industry Committee, New York State Legislature, Albany, N.Y., June 1968

Making Facilities Accessible to the Physically Handicapped, New York State University, State University Construction Fund, Albany, N.Y., July 1967

Manpower Directions, 1965-1975, Vols. I, II, Albany, N.Y.

McGowan, John F., ed., *An Introduction to the Vocational Rehabilitation Process*, Rehabilitation Service Series No. 555, U.S. Government Printing Office, Washington, D.C., 1960

The Minority Group Needs of the Deaf, New York State Temporary State Commission to Study the Problems of the Deaf, Albany, N.Y., 1968

Monthly Highlights, New York State Department of Social Services, Commission for the Blind and Visually Handicapped, New York, N.Y., September 1968

A Monthly Summary, Social Statistics, Vol. XXX, No. 6, June 1968

Multi-Family Zoning in Westchester County, Westchester County Department of Planning, December 1964

Muthard, John E. and Woodrow W. Morris, eds., *Counseling the Older Disabled Worker*, State University of Iowa, Iowa City, Ia., 1964

Nassau-Suffolk District Business Fact Book, 1967-1968 Edition, New York State Department of Commerce, Albany, N.Y.

National Citizens Advisory Committee on Vocational Rehabilitation: Report for The Secretary of Health, Education and Welfare, U.S. Government Printing Office, Washington, D.C., June 1968

The Negroes in the United States, Their Economic and Social Situation, Bulletin No. 1511, U.S. Government Printing Office, Washington, D.C., 1966

New York State Comprehensive Manpower Plan for Fiscal Year 1969, New York State Manpower Coordinating Committee, New York, N.Y., 1968

New York State Statistical Yearbook, New York State Division of the Budget, Office of Statistical Coordination, Albany, N.Y., 1967

Occupational Outlook Quarterly, Vol. II, No. 1, Washington, D.C., February 1967

Population Change in Westchester County 1900-1960, White Plains, N.Y., September 1966

Programs for the Disadvantaged, Office of the Disadvantaged and Handicapped, U.S. Government Printing Office, Washington, D.C., October 1966

Programs for the Handicapped, Office of the Disadvantaged and Handicapped, U.S. Government Printing Office, Washington, D.C., October 1966

Rehabilitation of Disabled Recipients of Public Assistance Grants or Those Whose Children are Recipients, Department of Education, State of Arkansas, Little Rock, Ark., February 1968

Report of the U.S. National Advisory Commission on Civil Disorders, U.S. Government Printing Office, Washington, D.C., 1968

Residential Market Analysis, Nassau-Suffolk Regional Planning Board, Hauppauge, N.Y., 1967

School District Data for Westchester County, White Plains, N.Y., December 1964

Spencer, Gary, *A Comparative Study of the Reduction of Dependency in Form Low-Income Housing Projects*, Northeastern University, Boston, Mass., 1967

A Survey of Medicine and Medical Practice for the Rehabilitation Counselor, U.S. Department of Health, Education and Welfare, U.S. Government Printing Office, Washington, D.C., 1966

Westchester-Rockland District Business Fact Book, 1967-68 Edition, New York State Department of Commerce, Albany, N.Y.

Witt, Leonard R., *Final Report on Project DEVELOP*, New York State Division of Parole, New York, N.Y., March 1968

Youth in the Ghetto: A Study of the Consequences of Powerlessness, Harlem Youth Opportunities Unlimited, Inc., New York, N.Y., 1964

APPENDICES

APPENDIX A

Descriptions of Career Ladder Positions in Rehabilitation Services

State of California

FACSIMILE

CALIFORNIA STATE PERSONNEL BOARD

specification

SCHEMATIC CODE: XJ80
CLASS CODE: 9951
ESTABLISHED: 7/12/68
REVISED: —
TITLE CHANGED: —

REHABILITATION SERVICE AIDE

Definition:

Under direct supervision in a program organized to provide remedial services for socially or economically disadvantaged persons; to provide routine nontechnical assistance and supporting services to clients and staff; to provide liaison between professional staff and disadvantaged individuals and groups in the community; to receive job readiness training; and to do other work as required.

Job Characteristics:

Social Service Aides are employed in State Service Centers and other State operations engaged in organized programs to meet the vocational, social and economic needs of the disadvantaged.

Appointments to positions in this class are made on the basis of a temporary authorization for a period not to exceed nine months. Aides will receive training on the job and in the classroom which is intended to bring the Aide to a higher degree of employability through increasing his skills and education in whatever areas of deficiency have left him in an unemployed or underemployed condition. Appointments are for the twofold purpose of providing work experience and training as well as for the performance of necessary budgeted productive work. Training is designed to develop employable work habits and skills for positions in and out of State service. Employees in this class are viewed as clients in training as well as employees, and are assigned to case workers for guidance and development.

Typical Tasks:

Greets clients, arranges routine appointments and transports or may accompany clients on appointments for services or for interviews; establishes and maintains liaison between the professional staff and disadvantaged to seek help through the programs available and assists in establishing favorable relationships; does errands and serves as messenger for staff; issues supplies and keeps supply records; maintains building and auto security, and reports on need for repair services; attends meetings; provides general assistance to the staff by performing other unskilled or routine tasks; may be assigned to short-term work assignments in the public or private sector to gather and pass on to other staff members firsthand information on the job characteristics, training programs, employer and employee attitudes of specific employers to facilitate the overall counseling, placement, job development and employer relations programs of the Service Center.

Minimum Qualifications:

Experience within the last ten years, either paid or unpaid, which has provided personal and firsthand knowledge of the problems, resources and residents of the specific community served by the Center, and which has developed the ability to relate to disadvantaged individuals and groups and to the staff of public and private agencies providing services.

and

Knowledge and abilities:
Knowledge of: the needs, problems, attitudes and behavior patterns of disadvantaged persons and of the total community.
Ability to: relate well to residents of the disadvantaged community and to representatives of public and private agencies providing services; read and write; accept and benefit from training.

and

Special personal characteristics: neatness; willingness to follow directions; and willingness to participate in prescribed classroom and on-the-job training.

Monthly Compensation: [3]$377 395 415

[3] Three-step range

Work Week Group: 4B

Note: Salary information for this class was correct on 7/15/68. Any subsequent salary changes have not been recorded.

FACSIMILE

CALIFORNIA STATE PERSONNEL BOARD

specification

REHABILITATION SERVICE ASSISTANT I

SCHEMATIC CODE: XJ70
CLASS CODE: 9946
ESTABLISHED: 7/12/68
REVISED: --
TITLE CHANGED: --

Definition:

Under direct supervision in a program organized to provide remedial services for socially and economically disadvantaged persons, either (1) to perform supporting services in the intake process or (2) to perform a wide range of duties related to assisting staff members having immediate case work responsibility or (3) to receive job experience in out-station work assignments; to provide liaison between professional staff and disadvantaged individuals and groups in the community; and to do other work as required.

Job Characteristics:

Social Service Assistants I are assigned in State Service Centers and other State and private operations engaged in programs to meet vocational, social and economic needs of the disadvantaged.

Although appointment is not limited to Social Service Aides, the class is designed to continue and expand the training of those with Aide-type experience to the extent that Social Service Assistant I training opportunities may develop the skills needed for employment in other civil service classes or in private industry. As determined by State Service Center training and supervisory staff, successful progress in the training program and in the individualized development plan is essential to continuation in the program and to the satisfactory completion of probation.

Typical Tasks:

Service Center Assignment: Greets and receives clients seeking services, informs clients of services available at the Center and in the community, and assists clients in filling out forms; may arrange routine appointments for clients and accompany them as needed; locates and provides follow-up with clients who have missed appointments; assists an effective delivery of services from outside the agency; may assist in developing immediate solutions to emergency problems and expediting delivery of needed services; as assigned, represents the Center in community, school, or inter-agency meetings; may serve on special task forces and study groups and may assist with research projects and participate in training other employees.

Out-Station Work Assignment: Performs a variety of progressively responsible and more difficult tasks designed to develop occupational skills in a specific job; observes working environment and job opportunities and learns attitudes necessary for success in the occupation; prepares periodic progress reports for the Service Center; may be assigned to short-term work assignments in the public or private sector to gather and pass on to other staff members firsthand information on the job characteristics, training programs, employer and employee attitudes of specific employers to facilitate the overall counseling, placement, job development and employer relations programs of the Service Center.

Minimum Qualifications:

Either:

1. Six months of experience as an aide or a trainee performing tasks related to a program providing remedial services to the disadvantaged; or

2. Completion of one year of college.

and

Experience within the last ten years, either paid or unpaid, which has provided personal and firsthand knowledge of the problems, resources and residents of the specific community served by the Center and which has developed the ability to relate to disadvantaged individuals and groups and to the staff of public and private agencies providing services.

and

Knowledges and Abilities:

Knowledge of: needs, problems, attitudes and behavior patterns of disadvantaged persons and of the total community.

Ability to: relate well to residents of the disadvantaged community and to representatives of public and private agencies providing services; read and write; and accept and benefit from training.

and

Special personal characteristics: neatness; willingness to follow directions; and willingness to participate in prescribed classroom and on-the-job training.

Monthly Compensation: $435 457 480 505 530

Work Week Group: 4B

Note: Salary information for this class was correct on 7/15/68.
Any subsequent salary changes have not been recorded.

FACSIMILE

CALIFORNIA STATE PERSONNEL BOARD

specification

SCHEMATIC CODE: XJ60
CLASS CODE: 9944
ESTABLISHED: 7/12/68
REVISED: --
TITLE CHANGED: --

REHABILITATION SERVICE ASSISTANT II

Definition:

Under supervision in a program organized to provide remedial services for socially or economically disadvantaged persons, to interview prospective clients, to identify their needs for program services, to record basic client information, and to refer accepted clients to appropriate staff for continuing assistance with their problems; to provide direct assistance in solving immediate problems; to report on community resources for the disadvantaged and on attitudes and activities of the disadvantaged in the local area; and to do other work as required.

Job Characteristics:

The class is designed to continue and expand training of the Social Service Assistant I whose skills are related to human service programs rather than to employment in other occupational areas. Experience in this class, together with satisfactory completion of a portion of the prescribed core training program, is qualifying for promotion to Counselor Associate.

The primary role of the Social Service Assistant II in the State Service Center Program is related to the intake process. This assignment may require multiple contacts with the client in preparation for assignment to a case-carrying counselor such as a Vocational Rehabilitation Counselor, Intake Counselor, Employment Counselor, Social Worker, or Parole Agent. The Social Service Assistant II positions do not entail the intensive interpersonal relationships characteristic of the case work process, and consequently, experience is not considered qualifying for professional-level counseling positions.

Typical Tasks:

Interviews prospective clients to determine their needs in areas relating to vocational rehabilitation, employment, social services, or other types of assistance available through the Service Center Program; assesses the immediacy of various problems; provides direct service in solving urgent problems and refers clients to the appropriate professional employee or service unit for continuing assistance with less urgent problems; may serve on special task forces and study groups; may assist in research projects and in the training of Aides and other Service Center employees; engages in community relationships to interpret the Center's functions to community groups and to relate the community's needs to the Center's personnel; establishes and maintains contact with disadvantaged persons in the community and encourages them to seek services; represents the Service Center in meetings with various community or interagency groups; as assigned, develops job opportunities for clients with various employers in the community and reports on working conditions, employee-employer relations.

Minimum Qualifications:

Either I

One year of experience in the California state service performing the duties of a Social Service Assistant I.

Or II

Either:

1. Two years of experience performing duties in a program providing remedial services to the disadvantaged comparable to a Social Service Assistant I in the California state service; or

2. Completion of two years of college.

and

Experience within the last ten years either paid or unpaid, which has provided personal and firsthand knowledge of the problems, resources and residents of the specific community served by the Center, and which has developed the ability to relate to disadvantaged individuals and groups and to the staff of public and private agencies providing services.

and

Knowledge and abilities:

Knowledge of: needs, problems, attitudes and behavior patterns of disabled and disadvantaged persons; community resources and services designed to meet needs of impoverished or socioculturally deprived persons.

Ability to: meet and deal effectively with disabled and disadvantaged persons in their own environment; understand and interact effectively with persons who live in impoverished and socioculturally deprived communities; earn the respect and confidence of other individuals; develop awareness and sensitivity to feeling, attitudes and trends among residents of the local community; interpret and apply rules and instructions; speak, read, and write effectively.

and

Special personal characteristics: Interest in disabled and disadvantaged persons and their problems; impartiality; neatness; emotional stability; clear enunciation.

Monthly Compensation: $505 530 556 584 614

Work Week Group: 4B

Note: Salary information for this class was correct on 7/15/68.
Any subsequent salary changes have not been recorded.

FACSIMILE

CALIFORNIA STATE PERSONNEL BOARD

specification

SCHEMATIC CODE: XJ55
CLASS CODE: 9942
ESTABLISHED: 7/12/68
REVISED: —
TITLE CHANGED: —

ASSISTANT REHABILITATION COUNSELOR ASSOCIATE

Definition:

Under professional supervision, to provide case work services to a selected limited case load of clients in a program organized to provide a wide range of social case work, vocational and remedial services for socially or economically disadvantaged persons; and to do other work as required.

Job Characteristics:

Experience in this class, together with required academic qualifications, is considered qualifying casework experience for journeyman counselor positions.

Typical Tasks:

Utilizes the individual social case work approach; provides counseling, supporting and follow-up services for a limited and selected client case load; assesses nature and extent of problems of clients assigned for counseling service; evaluates availability of services in the Center and in the community in relation to the client's needs; in cooperation with the client outlines a plan of action and provides supportive and follow-up services to the client in carrying out the plan; assists in developing community resources to meet clients' needs and may personally assist in effective delivery of services to meet specific clients' needs; periodically reviews clients' progress with Intake Counselor and participates in multidisciplinary staff meetings to assess clients' problems; as assigned, represents the Center in meetings with individuals and community groups; assists in research projects and in the training of lower level staff; as assigned, may have direct responsibility for the supervision and the evaluation of the work of a group of Social Service Aides.

Minimum Qualifications:

Either I

1. One year of experience in the California state service performing the duties of a Social Service Assistant II; or

2. Three years of experience in the California state service performing duties comparable to a Social Service Aide providing remedial services for socially or economically disadvantaged persons.

Or II

Experience: Four years of experience in a program organized to provide remedial services for socially or economically disadvantaged persons, groups and communities; and

Education: Completion of 15 units of college-level courses in the social sciences or a closely related field.

Or III

Education: Equivalent to graduation from college, preferably with a major in the social sciences or closely related field.

and

Knowledges and abilities:

Knowledge of: basic principles, procedures and techniques of social case work, vocational guidance, and correctional rehabilitation; emotional problems of culturally, ethnically and economically disadvantaged persons, groups and communities; principles of community organization; interviewing techniques; techniques of supervising and working effectively with others.

Ability to: utilize and apply effectively the required technical social case work knowledges; secure accurate social data and record such data systematically; relate to and gain the confidence of disadvantaged persons requiring services; establish and maintain cooperative relations with staff and those contacted in the work; supervise the work of others; secure and record data accurately and systematically; speak and write effectively; analyze situations accurately and take effective action.

and

Special personal characteristics: Interest in disabled and disadvantaged persons and their problems; impartiality; emotional stability, neat personal appearance.

Monthly Compensation: $584 614 644 676 710

Work Week Group: 4B

Note: Salary information for this class was correct on 7/15/68.
Any subsequent salary changes have not been recorded.

APPENDIX B

Manpower Requirements in Selected Areas

1969-1975

CIRCUMSTANCES EXPECTED TO INFLUENCE MANPOWER REQUIREMENTS IN THE PROFESSIONAL FIELD
1969-1975

Circumstance	Occupations Affected
Rising standard of living, bringing demand for more and better services	Teachers, doctors, research scientists
Growth of research and development in aero-space and other science and engineering fields	Mathematicians; physical scientists; engineers
Growth of medical and biological research	Life scientists and physicians
Greater complexity of industrial equipment and manufacturing processes	Electronic, industrial and mechanical engineers; chemists and other scientists
Growth of industries producing aero-space, electronic and other highly instrumented products	Electronic and mechanical engineers
Growth of chemical industries producing plastics, man-made fibres, pharmaceuticals, etc.	Chemists and biologists; chemical engineers
Expanding population, especially expanding youth population	Teachers; librarians; vocational counselors; social workers, doctors and nurses; child-care specialists
Medicare and Medicaid and extension of hospital insurance; demand for higher standards of medical services; new medical techniques and drugs; stress on rehabilitation	Doctors, nurses, dentists; therapists; life scientists; psychologists and psychiatrists; social workers
Expansion of state and local government programs, especially:	
in higher education	College teachers, research scientists
in air and water pollution control, local transportation, air terminal and highway development	Civil, sanitary and other engineers; planners; geologists; chemists and other scientists; statisticians
in care of narcotics addicts and physically and mentally ill	Doctors; nurses; medical and biological scientists; psychologists and psychiatrists; social workers, therapists
Human resource development	Manpower training specialists; occupational counselors; social workers, therapists; child-care specialists; economists and statisticians
Growth in construction industry (in part resulting from the transportation bond issue)	Civil and construction engineers; architects
Greater use of accounting information in business and government and expanded use of automatic data processing in program planning, operation, and evaluation	Accountants; systems analysts; programmers

CIRCUMSTANCES EXPECTED TO INFLUENCE MANPOWER REQUIREMENTS IN THE CLERICAL FIELD

1969-1975

Expansion Effect	Occupations Affected
Relatively rapid growth of large users of clerical personnel, especially finance, central offices, government and business and professional services	Most clerical occupations
Increase in the complexity of private business and of government, and in their paperwork requirements	Most clerical occupations
Spread of computer centers and application of computers to wider ranges of functions	Office machine operators, especially computer operators and key punch operators
Continued shift to self-service techniques in retail stores, resulting in expanding need for check-out service	Checkers and cashiers
Contraction Effect	
Greater use of "quick copy" equipment, dictating equipment, etc., which will expand productivity and thus reduce need for office workers performing relatively routine work	Typists, general office help
Spread of electronic data processing, automatic record-keeping processes; automatic reading devices, inter-office electronic communication, microfilm record-keeping, which will reduce relatively the amount of manual office operations.	Bookkeeping and other machine operators; key punch operators; statistical clerks; file clerks and other general office help, including those engaged in processing insurance records, payroll processing, billing, control of bank checks, and similar functions

NUMBER OF JOBS IN OPERATIVE OCCUPATIONS

NEW YORK STATE, 1965 AND 1975

(in thousands)

Occupations	Number of Jobs		Change, 1965-1975	
	1965	1975	Number	Percent
All operatives and kindred workers	1,269.8	1,319.0	+49.2	+ 3.9
Selected transportation and public utility operatives	280.1	313.8	+33.7	+12.0
Drivers: bus, truck, tractor	167.2	192.3	+25.1	+15.0
Deliverymen, routemen, cab drivers	94.9	106.3	+11.4	+12.0
Brakemen and switchmen, railroad	9.0	8.6	- 0.4	- 4.4
Power station operators	2.4	2.5	+ 0.1	+ 4.2
Sailors and deck hands	6.6	4.1	- 2.5	-37.9
Asbestos and insulation workers	1.3	1.4	+ 0.1	+ 7.7
Semiskilled metal-working occupations	110.1	113.3	+ 3.2	+ 2.9
Furnacemen, smelters, pourers and heaters	3.6	3.5	- 0.1	- 2.8
Welders and flame cutters	22.5	25.6	+ 3.1	+13.8
Electroplater helpers	1.6	1.7	+ 0.1	+ 6.3
Machine tool operators; metal-working class B	20.9	18.4	- 2.5	-12.0
Assemblers, metal-working, class B	44.9	47.0	+ 2.1	+ 4.7
Inspectors, metal-working, class B	16.6	17.1	+ 0.5	+ 3.0
Semiskilled occupations in textiles and apparel	98.0	81.7	-16.3	-16.6
Knitters, loopers and toppers	3.6	3.1	- 0.5	-13.9
Weavers and spinners, textile	2.0	1.2	- 0.8	-40.0
Sewers and stitchers, manufacturing	92.4	77.4	-15.0	-16.2
Other operatives and kindred workers	780.3	808.8	+28.5	+ 3.7
Attendants, auto service and parking	22.7	31.6	+ 8.9	+39.2
Laundry and dry cleaning workers	43.9	45.3	+ 1.4	+ 3.2
Meat cutters; except meat packing	33.3	37.9	+ 4.6	+13.8
Mine operatives and laborers n.e.c.	2.5	2.3	- 0.2	- 8.0
Other operatives and kindred workers n.e.c.	677.9	691.7	+13.8	+ 2.0
Textiles and apparel	153.2	125.3	-27.9	-18.2
Metalworking	161.9	179.7	+17.8	+11.0
Miscellaneous operatives	362.8	386.7	+23.9	+ 6.6

SOURCE: Manpower Directions, New York State Department of Labor, Division of Research and Statistics, New York State, 1965-1975.

REPORT

of

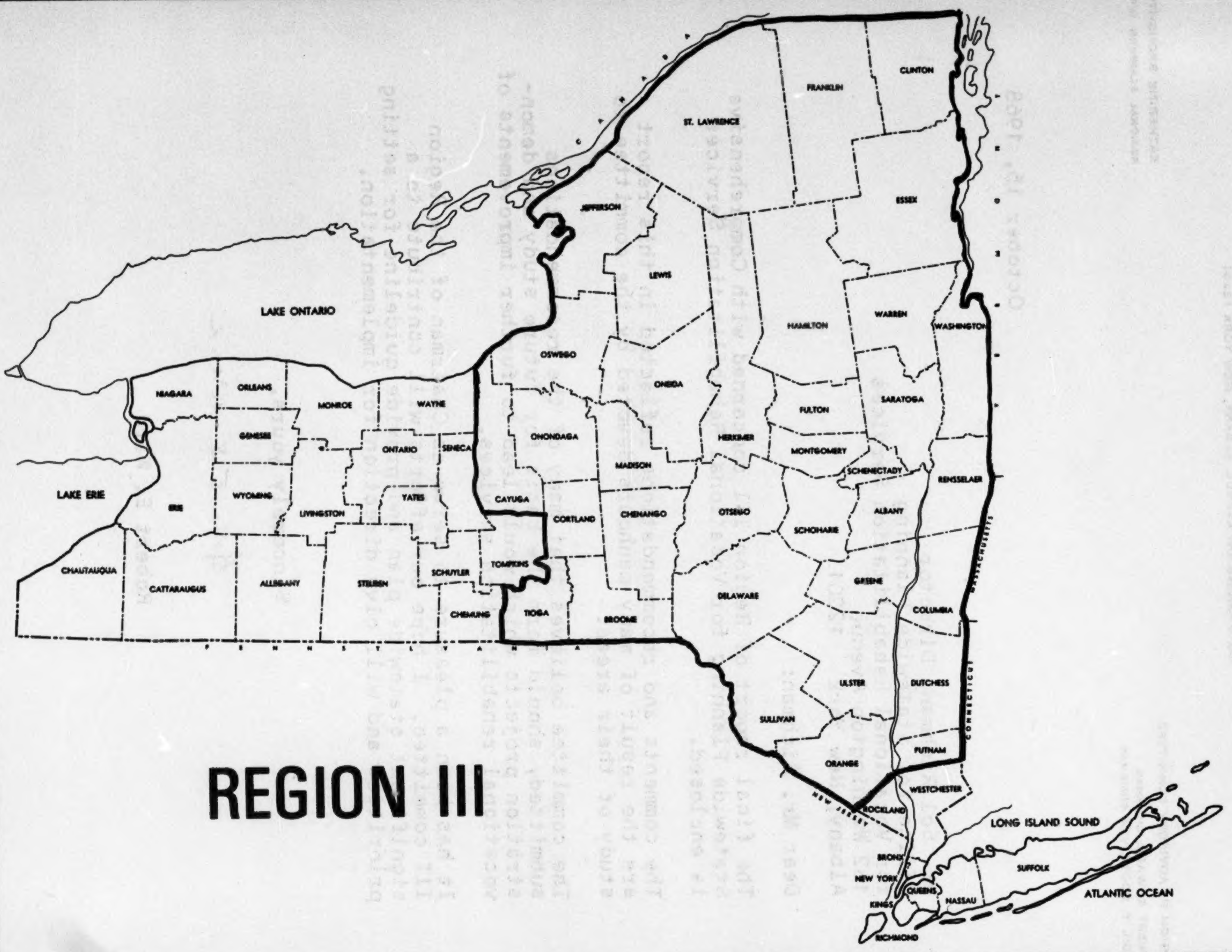
REGIONAL ADVISORY COMMITTEE

REGION III

Albany
Binghamton
Broome
Cayuga
Chenango
Clinton
Columbia
Cortland
Delaware
Dutchess
Essex
Franklin
Fulton
Greene
Hamilton
Herkimer
Jefferson
Lewis
Madison
Montgomery
Oneida
Onondaga
Orange
Oswego
Otsego
Plattsburgh
Poughkeepsie
Putnam
Rensselaer
Saratoga
Schenectady
Schoharie
St. Lawrence
Sullivan
Syracuse
Tioga
Ulster
Warren
Washington
Watertown

University of the State of New York
State Education Department
Office of Statewide Planning for Vocational Rehabilitation Services

October 1968



LAKE ONTARIO
LAKE ERIE
CLINTON
FRANKLIN
ST. LAWRENCE
ESSEX
JEFFERSON
LEWIS
HAMILTON
WARREN
WASHINGTON
OSWEGO
ONEIDA
SARATOGA
FULTON
HERKIMER
MONTGOMERY
SCHENECTADY
RENSSELAER
NIAGARA
ORLEANS
MONROE
WAYNE
GENESEE
ONTARIO
SENECA
ONONDAGA
MADISON
ALBANY
ERIE
WYOMING
LIVINGSTON
YATES
CAYUGA
CORTLAND
CHENANGO
OTSEGO
SCHOHARIE
GREENE
COLUMBIA
CHAUTAUQUA
CATTARAUGUS
ALLEGANY
STEUBEN
SCHUYLER
TOMPKINS
CHEMUNG
TIOGA
BROOME
DELAWARE
ULSTER
DUTCHESS
SULLIVAN
ORANGE
PUTNAM
WESTCHESTER
ROCKLAND
BRONX
NEW YORK
QUEENS
KINGS
RICHMOND
NASSAU
SUFFOLK
LONG ISLAND SOUND
ATLANTIC OCEAN
PENNSYLVANIA
NEW JERSEY
CONNECTICUT
MASSACHUSETTS

REGION III

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
OFFICE FOR STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION SERVICES
162 WASHINGTON AVENUE, ALBANY, NEW YORK 12201

REGION III ADVISORY COMMITTEE
ROBERT E. WARD, CHAIRMAN
BASIL Y. SCOTT, VICE CHAIRMAN

KATHERINE BROUGHTON
REGIONAL PLANNING DIRECTOR

October 15, 1968

Mr. Sol Richman, Director
Office for Statewide Planning
for Vocational Rehabilitation Services
162 Washington Avenue
Albany, New York 12201

Dear Mr. Richman:

The final report of Region III concerned with Comprehensive Statewide Planning for Vocational Rehabilitation Services is enclosed.

The comments and recommendations reflected in this report are the result of many manhours devoted by the committee to study of their areas.

The committee believes that many of the recommendations submitted, should form the basis for future study and demonstration projects which would lead to further improvements of vocational rehabilitation services.

It has been a pleasure to serve as Chairman of the Region III committee. I hope our efforts will contribute to a significant statewide plan and provide guideline for setting priorities and will give direction for implementation.

Sincerely yours,

Robert E. Ward

Robert E. Ward

TABLE OF CONTENTS

Regional Map 245

Regional Committee Members and Consultants 250

Foreword 255

Introduction 256

Identification of the Disabled 260

Provision of Service Programs 262

Manpower 272

Role of Government Agencies 278

Financing of Services for Vocational Rehabilitation 284

Special Areas of Concern 288

Legislation 292

References 294

Appendices 296

- Appendix A - Estimates of Disability 298
- Appendix B - District Recommendations 300
- Appendix C - Position Papers 304

REGION III

Robert E. Ward Chairman	Basil Y. Scott Vice-Chairman

EXECUTIVE COMMITTEE

District 1

Thomas Murphy	Chairman
Richard Staszak	Vice-Chairman

District 2

Jerome Resnick	Chairman
Edwin L. Hunger	Vice-Chairman

District 3

Alexander Ducanis	Chairman
Walter E. Mulholland	Vice-Chairman

District 4

Arthur M. Pauline	Chairman
Spencer Parrott	Vice-Chairman

District 5A

Arthur C. Stever, Jr.	Chairman

District 5B

Alva Channel	Chairman
Brooke Jennings, II	Vice-Chairman

Division of Vocational Rehabilitation
Harry B. Certner
Catharine M. Grace
Charles Schilling

Commission for the Blind and Visually Handicapped
Ralph Kurr

REGIONAL ADVISORY COMMITTEE

Viola Abel, Occupational Therapy Consultant
New York State Department of Mental Hygiene
Albany

Jacqueleine C. Archer, Executive Director
Alcoholism Information and Referral Center
Physicians Medical Center
Plattsburgh

Edward Ayres, Assistant Director
Bureau of Alcoholism
New York State Department of Mental Hygiene
Albany

Robert W. Bacorn, M.D., Regional Health Director
New York State Department of Health
Syracuse

Francis C. Barker, Coordinator
Special Education Work-Study Program
City School District
Syracuse

James Bordley III, M.D., Director Emeritus
Mary Imogene Bassett Hospital
Cooperstown

Paul C. Bosse, Director
Mental Health Information Services
Albany

Elliot Buck, Senior Rehabilitation Representative
Workmen's Compensation Board
Syracuse

Henry A. Bunn, Executive Vice-President
Wilbur National Bank
Oneonta

Gerald W. Burke, Executive Secretary
United Community Chest and Council of Onondaga
County, Inc.
Syracuse

Larry Burwell, Executive Director
Urban League of the Albany Area, Inc.
Albany

William E. Busacker, Administrative Assistant
Herkimer County Board of Cooperative
Educational Services
Herkimer

Mrs. C. J. Carey, Executive Director
Empire Housing Foundation
Malone

Alexander F. Carson, M.D., Medical Director
Department of Physical Medicine and Rehabilitation
Fox Memorial Hospital
Oneonta

Harry B. Certner, District Supervisor
Division of Vocational Rehabilitation
New York State Education Department
Albany

Alva Channel Executive Director
Council of Community Services of Plattsburgh and
Clinton County
Plattsburgh

Harold B. Christian, Field Consultant
New York State Office of Economic Opportunity
Binghamton

Joseph L. Cohen, President
Albany Branch, National Association for the
Advancement of Colored People
Albany

Sy Cohen, Union Representative
Central Labor Union Council
Hudson

Thomas A. Coughlin, President
Jefferson County Chapter
Association for Retarded Children
Watertown

Dorothy Crugnale, Administrative Director
Cerebral Palsy Center
Albany Medical Center Hospital
Albany

Dorothy Cushman, Executive Director
Rensselaer County Tuberculosis and
Public Health Association
Troy

Homer P. Dearlove
District Superintendent of Schools
Fort Edward

Lucretia Diggs, Community Specialist
Division of Employment
New York State Department of Labor
Albany

John Dillon, Executive Officer
Board of Cooperative Educational Services
Hamilton, Warren and Washington Counties
Schroon Lake

C. Walter Driscoll, Area Director
New York State Department of Social Services
Syracuse

Alexander J. Ducanis, Director
Institutional Research
State University of New York at Binghamton
Binghamton

John L. Duell, Jr., Chairman
Chenango County Mental Health Board
McDonough

Fred Eaton, Editor
The *Saratogian*
Saratoga

Lawrence B. Feinberg, Coordinator
Rehabilitation Counselor Training Program
Syracuse University
Syracuse

Maurice Finnegan, President
Franklin County Board of Cooperative Services
Malone

Walter J. Finnegan
Supervising Clinical Psychologist
Putnam County Mental Health Center
Mahopac

Sumner Forward, District Superintendent
Division of Employment
New York State Department of Labor
Syracuse

Beryl W. Freeman, Commissioner
Lewis County Department of Social Services
Lowville

Gail A. Gaines, M.D., Executive Director
Putnam County Community Mental Health Services
Carmel

Peter F. Gallagher, Director
Personnel and Public Relations, Masonic Home
Utica

Cornelius J. Gannon, Executive Secretary
Broome County Committee on Alcoholism
Binghamton

Catherine M. Grace, District Supervisor
Division of Vocational Rehabilitation
New York State Education Department
Poughkeepsie

Sheldon A. Grand, Director
Rehabilitation Counseling Program
State University of New York at Albany
Albany

Thomas A. Grey, Commissioner
Jefferson County Department of Social Services
Watertown

Milton Goldstein, Executive Director
The Workshop, Inc.
Menands

John Halligan, Area Supervisor
Division of Parole
Executive Department
Albany

John E. Haith, Executive Assistant
New York State Narcotic Addiction
Control Commission
Albany

James T. Hepinstall
Superintendent of Schools
Albany

Beatrice S. Herman, President
League of Women Voters of Albany County
Slingerlands

James P. Heron, Executive Director
Albany Council of Community Services
Albany

David J. Hopkins, Commissioner
Oswego County Department of Public Welfare
Mexico

Edwin L. Hunger, Superintendent
Poughkeepsie Public School System
Poughkeepsie

Carlyle Jacobsen, M.D., Executive Director
Hospital Review and Planning Council of Central
New York
Syracuse

Brooke H. Jennings II, Executive Director*
Association for Retarded Children
Plattsburgh

Leo Jivoff, M.D., Director
Department of Rehabilitation Medicine
State University Hospital of Upstate Medical
Center
Syracuse

Howard Joseph
Oneonta

Bernard F. Kalina, M.D., Executive Director
Community Mental Health Clinic
Liberty

Seymour Katz, Area Director
New York State Department of Social Services
Albany

Glenn M. Kendall, Superintendent
New York State Vocational Institution
West Coxsackie

Herman P. Kessler, Field Consultant
New York State Office of Economic Opportunity
Albany

Ralph J. Kurr, Senior Rehabilitation Counselor
Commission for the Blind and Visually Handicapped
New York State Department of Social Services
Syracuse

Joseph P. Landauer, Executive Director
Watertown Community Chest, Inc.
Watertown

Reverend William M. Lange, Jr.
Church Mission to the Deaf
Syracuse

Charles J. MacVean, Executive Director
Fulton County Association for
Retarded Children, Inc.
Gloversville

Joseph L. Maxwell, Area Director
Division of Parole
Executive Department
Syracuse

Walter E. Mulholland, Consultant Psychologist
New York State Department of Social Services
Cortland

Thomas Murphy, Executive Director
Community Service of the Mohawk-Hudson Area
Troy

Helen C. McBride, Executive Director
Central Association for the Blind, Inc.
Utica

Edmund McCann, Director of Social Services
Albany Association of the Blind, Inc.
Albany

Marie McCarthy, Director
Occupations, Inc.
Middletown

James J. McCormack, Director of Planning
Broome County Social Planning Council, Inc.
Binghamton

Alan McKittrick, Rehabilitation Counselor
Workmen's Compensation Board
Albany

Daniel P. McMahon, M.D., Regional Health Director
New York State Department of Health
Albany

Oliver M. Nikoloff, Professor
Department of Educational Psychology
State University of New York at Albany
Albany

David Paradine, Executive Director
Orange Area United Fund, Inc.
Newburgh

Spencer Parrott, Professor
School of Citizenship and Public Affairs
Syracuse University
Syracuse

Arthur M. Pauline, Executive Director
Department of Rehabilitation Medicine
State University Hospital of the Upstate Medical Center
Syracuse

Dorathy Perry, Director
Pupil Personnel Services
Oneonta City School District
Oneonta

Elizabeth Ragan, Senior Employment Counselor
Division of Employment
New York State Department of Labor
Albany

Jerome Reznick, Executive Director
Rehabilitation Programs, Inc.
Poughkeepsie

Francis U. Ritz, Assistant Manager
International Business Machines Corporation
Poughkeepsie

Milton Rosenblum, Executive Director
Syracuse Association of Workers for the Blind, Inc.
Syracuse

Charles Schilling, District Supervisor
Division of Vocational Rehabilitation
New York State Education Department
Albany

Basil Y. Scott, Director of Program Development
New York State Department of Motor Vehicles
Albany

John H. Servis, Regional Director
Hospital Review and Planning Council,
Northeastern New York
Albany

Joseph Sheehan, Senior Rehabilitation Counselor
Division of Vocational Rehabilitation
New York State Education Department
Binghamton

Curlean Shelton, President
Syracuse Branch, National Association for the Advancement of Colored People
Syracuse

Frank S. Sirianni, Executive Director
United Cerebral Palsy and Handicapped Children's Association of Syracuse, Inc.
Syracuse

Sister M. Ann Elizabeth, Administrator
Saint Francis Hospital
Poughkeepsie

Stanton B. Smith, Chairman
Manpower Coordinating Council
Canton

Alan Speiser, Executive Director
Consolidated Industries of Greater Syracuse, Inc.
Syracuse

Richard J. Staszak, Commissioner
Schenectady County Department of Social Services
Schenectady

Arthur C. Stever, Jr., President
Jefferson County Industries, Inc.
Watertown

Evelyn P. Storer, Managing Director
Sheltered Workshop for the Disabled, Inc.
Binghamton

John Sullivan, Executive Director
Gateway Industries
Kingston

Robert Sullivan, Associate Probation Consultant
Division of Probation
New York State Department of Correction
Albany

Emile B. Truchon, Senior Rehabilitation Counselor
Division of Vocational Rehabilitation
New York State Education Department
Malone

Genevieve Ward, Executive Secretary
Jefferson County Association for the Blind, Inc.
Watertown

Robert E. Ward, Executive Director
Sunnyview Hospital and Rehabilitation Center
Schenectady

John N. Weems, Executive Director
Cayuga County Association for Retarded Children
Auburn

Keith Williams, Director
Community Welfare Council of Schenectady
Schenectady

W. Fowler Wilson, Program Director
Schenectady County Association for Retarded Children, Inc.
Schenectady

Edmund B. Wutzer, Probation Consultant
Division of Probation
New York State Department of Correction
Syracuse

James F. Zinck, Managing Director
Blind Work Association, Inc.
Binghamton

CONSULTANTS

H. Kenneth Fitzgerald
Syracuse

Hiram H. Frank
North Branch

Richard F. Grego
South Fallsburg

Jeanette Gevov
New York City

Mrs. Bernard F. Kalina
Liberty

Joseph F. Rudmin, M.D.
Plattsburgh

Samuel Sanes, M.D.
Syracuse

Francis J. Sorino
Liberty

FOREWORD

This report covers many aspects of vocational rehabilitation services. Members of the Region III Committee, primarily at the five district levels, have devoted much time to the study of their respective areas. The comments and recommendations reflected in this report are the result of their work. It should be noted that the committee membership represents many different vocations and leadership positions in the communities of our region. It is also important to note that, geographically, Region III covers very diverse population groups ranging from a number of major metropolitan areas to remote rural communities. The Region also presents many different types of problems influencing the effective delivery of vocational rehabilitation services.

It is difficult to capsulize the material covered in this report. However, the three major concerns which repeatedly came up during discussions throughout the region were manpower, financing of rehabilitation services, and strong, central, coordinated state leadership for rehabilitation programs. Time did not permit an in-depth study of all the topics of concern. It is the Committee's hope that the recommendations should form a basis for a future study which would lead to further improvement of vocational rehabilitation services. A number of the recommendations also offer excellent opportunities for research and demonstration projects.

Our State Committee Chairman, Byron Hipple, commented,

> **"If we can but begin to point direction and assess our priorities of attainment, we shall have accomplished much. We have but to look around us to observe the frustrations engendered by programs which, while signifying past recognition of social issues, have failed in the main to take the long look ahead toward ultimate goals and objectives. Hence, they have failed to set any orderly and feasible scheme of priorities for progressive development. As a result, we have witnessed periodic crises of policy; improvisations and 'crash' programs; misuse and abuse of resources; and alienation of both the public from which support must be drawn, and the public for whom these services are presumably designed. Our interest in and concern for rehabilitation services has not been untouched by these phenomena."**

Appreciation is particularly due to Mrs. Katherine Broughton, Regional Planning Specialist and her staff for outstanding services to the regional committee. Mrs. Broughton attended nearly all meetings of the district committees and many sub-committee district meetings and has worked arduously to make our effort meaningful. Acknowledgement is also made for the support given to the regional committee by Sol Richman, Raymond Klein, Raymond Osterhout and other staff members. Division of Vocational Rehabilitation district supervisors and their counterparts in the Commission for the Blind and Visually Handicapped have been most cooperative with district and regional committees.

Robert E. Ward
Chairman
Region III

INTRODUCTION

Context of the Planning Effort

Planning for the future takes place in and is influenced by an environment. The most effective planning takes cognizance of the interplay of environment factors which set limits and trends for what can reasonably take place in the future. Some of the factors noted by the Region III planning group are:

- The increasing advances in science which are prolonging life and ameliorating or curing more diseases than ever before, and which are improving the quality of life through transportation, communication, social services.
- The growing economy more managed and stable than in the past which permits more people to live in relative affluence.
- The government response to human needs in the form of more and better service programs.

While life in general seems better for most Americans, problem areas exist and new ones seem likely if some present trends continue. The Committee recognized some of these problem areas, particularly as they relate directly or indirectly to vocational rehabilitation planning:

- While many citizens live or expect to live in affluence, there is for the poor and the minority groups, a large gap between expectation and chance of attainment.
- Although programs to meet urgent needs have mushroomed, governmental institutions are and will increasingly be hard-pressed to serve all the people in need in the face of growing demand.
- Resources for new programs are being strained as rural migration to urban areas increases the latter's financial burden and decreases the farmer's tax and fund raising ability. The migration from cities to suburbs also produces a similar problem.
- The allocation of scarce resources creates problems. National, state and local priorities are difficult to establish equitably and a vast number of our citizens do not understand or accept them.

The implication of these factors on planning is enormous and complex. As more of the population participate in and influence planning, stress results as change proceeds more rapidly than attitudes and structures can accommodate them. The pressures for more rapid change can lead to improper or incomplete planning. If rehabilitation programs are to serve substantially increased numbers, the planning and resources of both government and the private sector to be effective and efficient must be prepared for the results of change. Constant evaluation should be part of new programs to assure that the most effective choices are being made within the framework of a fluid society.

Profile of the Planning Region

Region III is one of four regions established in the State of New York for the purpose of developing a Comprehensive Statewide Plan for Vocational Rehabilitation Services. For planning purposes, the Region was subdivided into five districts. One district was subsequently subdivided because of the transportation problems of its members in attending meetings. The districts and counties covered are as follows:

District I	Albany Warren, Fulton, Saratoga, Washington, Montgomery, Schenectady, Rensselaer, Schoharie
District II	Poughkeepsie Sullivan, Ulster, Greene, Columbia, Dutchess, Orange, Putnam
District III	Binghamton Cortland, Chenango, Tioga, Broome, Otsego, Delaware
District IV	Syracuse Oswego, Oneida, Onondaga, Madison, Cayuga, Herkimer
District V-A	Plattsburgh Essex, Clinton, Franklin

District V-B Watertown
Hamilton, St. Lawrence, Jefferson, Lewis

Region III consists of thirty-five counties reaching from Rockland and Putnam Counties in the south to the Canadian border in the north, and from Vermont and Massachusetts borders in the east to Cayuga County in the west. The population of the Region is 3,565,053 which is 20 percent of the state total. Four major metropolitan areas are located in the Region: Albany-Schenectady-Troy with a population of 687,776; Syracuse, 619,367; Utica-Rome, 356,000; and Binghamton with 367,997.

Region III is served by seven state hospitals, five state schools, three prisons, two medical centers, one primary rehabilitation center in Syracuse, one primary rehabilitation complex in Albany-Schenectady, 37 workshops and vocational rehabilitation centers and a myriad of public and private community services. The major characteristic of the Region is its diversification. This ranges from metropolitan populations of various sizes to the most remote rural areas of the state. The highway system connecting the Region has improved tremendously in the last decade. Likewise, services available in the Region have grown significantly.

Committee Operations

Region III has been fortunate in having so many knowledgeable and concerned people who, in addition to their own work, have willingly carried the responsibility for developing a regional plan for vocational rehabilitation services. The stimulus of the planning effort helped generate new dialogues between individuals and agencies and provided a vehicle for members of the committees to share the concerns of different sections of the Region. The creative thinking of the Committee led to new approaches to the problems which face individuals and agencies in our society today.

Selection of committee members and their appointment to the regional and district committees was made by James E. Allen, Jr., New York State Commissioner of Education. The regional and district committees were subsequently given an opportunity to recommend appointment of individuals in their areas to committee membership or to serve as consultants.

The organizational meeting of Region III was held on September 28, 1967. Key members of the state vocational rehabilitation agencies participated in this meeting which included the Chairman and Vice-Chairman of the Region and of each district. The purpose of the meeting was to give a general overview of planning activity and to prepare for organizational meetings in each district. The State Agency officials attending the meeting were Adrian Levy, Assistant Commissioner of Education for the Division of Vocational Rehabilitation, Oscar Friedensohn, Director of the Commission for the Blind and Visually Handicapped, and Sol Richman, Director of the Office of Statewide Planning for Vocational Rehabilitation Services. Organizational meetings of each district were held following this meeting and were attended by representatives of the Office of Statewide Planning for Vocational Rehabilitation Services, by the Regional Chairman and/or Vice-Chairman of each district committee, representatives of the Division of Vocational Rehabilitation, and the Commission for the Blind and Visually Handicapped, and the Secretary to the Committee.

Each of the district committees met in October for organization and orientation. Three of the district committees met monthly as committees of-the-whole and their sub-committees met at least once a month and sometimes more frequently. The sub-committees of the other district committees met once or twice a month and came together every two or three months for progress report sessions. The districts held a total of 78 meetings to develop their recommendations and devoted an estimated total of 10,000 man-hours to these meetings. This effort is most commendable, as the membership of the districts consisted of community leaders who had extremely busy schedules. In many instances, persons not on the committee furnished material or advice to committee members that was of great assistance. Each district chairman was permitted to organize his own district committee in the manner which he thought would best contribute to the development of recommendations in his district. It was felt that such an organization pattern would result in different views being developed which would then be considered in developing regional recommendations. The Regional Planning Director attended meetings of nearly all committees and provided administrative support. All of the districts in Region III had intended to hold public hearings to give local agencies, individuals and members of other planning groups an opportunity to express their concerns in the area of rehabilitation. Due to the pressure of time, the hearings were cancelled. However, the districts invited people in their area to submit position papers or expressions of their concerns. Some papers arrived after the deadline set by the Committee. They have not been included, but Appendix C contains representative recommendations.

Communities all over the Region became more aware of rehabilitation services as a result of the committee's efforts to determine the needs of their districts. Forty people served as resources to the committees, sharing their knowledge and expertise. On several occasions committee members brought guests to the district meetings. Some of the guests were involved in other community or state planning efforts and their participation led to fruitful discussions. "Shirt-sleeve" sessions which brought together people in the community who are experts in their respective fields were productive. As a result of this type of meeting,

District I developed a strong recommendation for a multi-service center in Albany, similar to the California concept of such a center. It should also be noted that as a by-product of this study many community leaders became more aware of the rehabilitation process and of the services which are available through it.

Great value was placed by the Committee on the very helpful and active participation of the staff members of the operating rehabilitation agencies, the Division of Vocational Rehabilitation and the Commission for the Blind and Visually Handicapped. Their knowledge of the communities and their insights into community services gave strong support to the work of the Committee.

IDENTIFICATION OF DISABLED

Total Disability Estimates

The Committee reviewed preliminary statistical reports submitted by the Office for Comprehensive Statewide Planning for Vocational Rehabilitation Services, Demographic Projections for New York State Counties prepared by the Office of Planning Coordination, and Basic Statistics for Counties in Metropolitan Areas of New York State for 1967 prepared by the New York State Department of Commerce. From this material, it was estimated that the total population of Region III would be 4,057,935 by 1975, a projected increase of 15 percent over the 1965 population. Of this population, it is estimated that approximately four percent will be unable to carry on their major activity because of disability. This number in Region III is estimated to be 168,700. Included are 96,551 disabled due to chronic conditions; 10,456 disabled because of mental and nervous conditions; and 61,693 disabled by mental retardation. Of this disabled group 94,331 are under 65. National statistics available from the Department of Health, Education and Welfare furnished some additional information indicating that our aging population will decrease from 487,641 in 1965 in Region III to 413,302 by 1975. (See Appendix A.) However, the Committee feels there should be an outreach program for those older persons who are eligible for vocational rehabilitation services, especially the older persons living in rural areas.

All of the districts found difficulty in collecting meaningful statistics related to this study. Collection was approached in several ways. Several districts developed comprehensive questionnaires or interview schedules in order to obtain estimates on the prevalence and incidence of handicapped persons within the district. Upon return of the questionnaires, an attempt was made to arrive at meaningful and reliable statistics. Except for the blind, who are counted in a registry, the Committee felt that the duplication in count, confidentiality of records, and lack of available information in many locales made the estimates in their district unreliable. There are no accurate indices for disabilities in the state or, for that matter, in the nation. The general statistics provided only guidelines rather than pertinent statistics applicable to any specific location. Utilization of the federal census and/or a state data bank system are two methods which might resolve this problem. As a beginning, the Committee suggests that questions pertaining to handicapped persons be included in the 1970 Federal Census.

> THE COMMITTEE RECOMMENDS THAT EFFORTS SHOULD BE MADE IN THE FUTURE TO IMPROVE AND PROMOTE BETTER DEVELOPMENT OF STATISTICAL DATA WHICH WOULD BE OF USE TO THE GOVERNMENT, VOLUNTARY AGENCIES, AND PLANNING GROUPS IN PROJECTING SERVICE NEEDS.

Disability Populations

Visually Disabled

The registered blind population in Region III in 1965 was 5,333 and 13,191 were visually handicapped. By 1975, it is estimated that there will be a total of 22,783 blind or visually handicapped persons who could benefit from rehabilitation services in the Region.

Hearing Disabled

While concern was expressed concerning identification of those who are disabled due to hearing impairment or deafness, no statistics on deafness were available. The New York State School for the Deaf is located in Region III. This is a residential school serving from 150 to 250 pupils of preschool age through secondary grades. Deaf children are now being provided services in Albany, Schenectady and Syracuse in classes of local school programs. These day classes presently serve a total enrollment of 75.

Mentally Disabled

It is estimated that in Region III by 1975 there will be 50,465 mentally disabled and 297,749 mentally retarded persons. It is expected that this number of disabled individuals will increase proportionately as the population increases. There was insufficient time for the committees to further identify this population or review the range of services these groups are now receiving. It was noted that there has been significant expansion in programs and plans for new programs to serve these groups both in the state hospital system and in private facilities. There has been an expansion of services to retarded children in many communities.

Many handicapped persons in the state are able to attend public and private educational institutions at all levels from kindergarten to college. The number of children served in special classes for the mentally retarded increased from 20,040 in 1956 to 38,741 in 1966. Enrollment in special classes for trainable mentally retarded children in the state increased from 928 in 1957 to 5,143 in 1966. In 1967 the special classes in New York State in public schools were:

	Number of Classes	Enrollment
Mentally retarded - trainable	491	5,143
Mentally retarded - educable	3,056	38,741

There are additional special education programs, some of which operate in conjunction with rehabilitation facilities for the physically disabled. However, the exact number of this population was not ascertainable during the study. A number of rehabilitation facilities in the area now offer remedial education as part of their vocational training programs. Statistics on these programs also were not available.

Disability Related to Income

It appears to the Committee, from information obtained during the study, that the poor have a higher incidence of disability than the general public. Committee members felt this was easier to identify among the urban poor. However, they are aware that similar problems exist among the rural poor. The 1967 Manpower Report of the President indicates that the proportion of men unable to work in urban poverty areas in the age group 25-54 is approximately 50 percent. According to Senator Thomas LaVerne's report, The Manpower Paradox, hardcore unemployed tend to be nonwhite and reside for the most part in urban centers. The Committee felt that the problems of this group require a multitude of services including health and vocational rehabilitation services together with a sufficient financial maintenance program to provide an adequate standard of living, which should be provided by or through the vocational rehabilitation program.

Disability Related to Age

All of the districts indicated concern that disabled individuals be identified as early as possible. It was felt that such early identification would aid in projecting services which would be required in the future. For example, "well baby" clinics as well as school health programs could provide a mechanism for early identification. Early identification would also enable services to be initiated at an earlier age, which might very well prevent or substantially reduce the rehabilitation services which otherwise would be required when the child reaches employment age.

Prison Population

Time did not permit the committees to consider the identification of inmates of state and county prisons who might benefit from rehabilitation services. It is believed these individuals should be identified and included in projected rehabilitation programs. It was reported that some of the correctional institutions in the region now provide rehabilitation services to their inmates. However, the scope of these services and identification of the type of individuals served were not identified by the Committee.

Workmen's Compensation Cases

Claims filed for Workmen's Compensation make this group of disabled readily identifiable. Arrangements now permit review of certain of these claims with personnel of the Division of Vocational Rehabilitation. Intensified efforts should be made to identify those in this group who need and would benefit from vocational rehabilitation, particularly those who might not return to employment unless services are initiated at an early stage. Many of the recommendations in material covered elsewhere in this report relate to this group of disabled.

PROVISION OF SERVICE PROGRAMS

Service Providers

The wide spectrum of vocational rehabilitation services now available in the Region are either provided or paid for by government and voluntary agencies. Most of the services are purchased with funds from the State vocational rehabilitation agencies or the many voluntary facilities located throughout the Region. The range of services is extensive and has shown considerable growth and professional development within the last ten years.

In review, this development has been made possible by combining the resources of both the government agencies and voluntary agencies. It is felt that the combining of resources and mutual cooperation should be continued to provide the best mechanism for delivering rehabilitation services to the disabled. The role of the voluntary agency develops community involvement, community financial support and individual community initiative for rehabilitation service programs. The State agencies, in turn, assist the community in establishing and improving services and assist in payment for these services when the client is not otherwise financially covered. It is believed that by strengthening the combined resources of the government and voluntary agencies, more people can be served and a better program established than could possibly be accomplished if the service system was developed and operated by either group independently.

Vocational Rehabilitation as a System

The Committee sees vocational rehabilitation as a system to take into account new needs and existing problems that are not being solved by existing systems. It is a creative process which puts things together in new patterns to conform to changing needs. The specific problem, then, is one of developing a system which in itself will permit change. It is also necessary, when dealing with a universal problem such as disability, to recognize the fact that there is great variation among localities. Some such variations may be on the basis of a demographic, geographic, economic or social characteristics of the area served. This system, in addition to having the ability to be flexible in meeting changing needs, should also be able to vary to respond to local and area needs. For example, the problems encountered in New York City with a highly developed transportation system are not really relevant to the rural areas, and any system for providing vocational rehabilitation services should of necessity permit variation.

Another dimension of the problem is that of the active-passive characteristics of the system. In defining these, we might think of a passive system as a closed one, entry into which is the responsibility of someone outside the system. Such a system can exist for many years without disruption since the person entering it essentially chooses it. On the other hand, an active system is one in which there is a built-in process which seeks out new entries into the system and is dynamic since it must change to adapt to these new entries. Any system which is designed should, for example, take into account the provision of services to rural counties. It should be designed in such a way that it is active in seeking contacts with persons in the rural areas who are in need of service, since it is apparent that those most in need of vocational rehabilitation in the rural areas are those who are most unlikely to seek it in the central urban area.

Examination of the boundaries of Region III indicates another type of systems problem, the one of the artificial barrier which may be created by state lines. The barrier becomes real when services are provided on the basis of residence in some political subdivision. For example, studies have shown that Binghamton provides health services and economic and commercial service to portions of Susquehanna and Bradford Counties in Pennsylvania. Therefore, the design for any system should provide for the realities of individual needs which are not related to the accident of state boundaries.

Sparsity of population within an area is not uniform. There are what might be called primary nodes and secondary nodes of population. Any system which is developed should recognize the existence of these secondary nodes and perhaps utilize them as centers where the surrounding rural population may be served. For example, a mobile unit system might be set up working out of the primary nodal area which would, on a rotating basis, serve the secondary nodes.

> THE COMMITTEE RECOMMENDS THAT THE STATE VOCATIONAL REHABILITATION AGENCIES SHOULD CONTINUE TO SERVE AS A STIMULUS TO VOLUNTARY AGENCIES IN DEVELOPING, INITIATING OR IMPROVING VOCATIONAL REHABILITATION SERVICES. THE EXPANSION OF SERVICES SHOULD CONTINUE TO BE A JOINT EFFORT UTILIZING RESOURCES AVAILABLE FROM BOTH PUBLIC AND PRIVATE AGENCIES. STATE AGENCIES SHOULD ONLY PROVIDE SERVICE PROGRAMS WHEN THESE SERVICES CANNOT BE OBTAINED FROM ANY VOLUNTARY AGENCY.

The Service Process

Application for services available from the Division of Vocational Rehabilitation or the Commission of the Blind and Visually Handicapped is usually initiated by counselors in one of the offices at the locations mentioned earlier. Following application, the counselors can obtain or buy any services which are authorized. At times there may be substantial delays in arranging appointments with professional persons who are outside the agency and whose examination reports are required for establishment of eligibility and used as a basis for counseling and planning.

When the evaluation process has been completed, and services to be provided have been determined, it is important that there be good coordination to insure that services are provided in the right sequence, in the minimum amount of time and with the best degree of coordination possible. It is important that the client not be lost between different components of the service process and that there is follow-through to insure this until the end result is obtained and sustained. Both state and voluntary agencies should cooperate to develop adequate controls which insure coordination and continuity of services. Responsibility for this should be assigned.

Current regulations stipulate that the agency must complete supporting data before the counselor may recommend and obtain approval for a rehabilitation program. The Committee found that there is considerable lag at times between the intake interview and the onset of service. Efforts should be made to minimize the amount of time that lapses between the initial inquiry or referral of the client and the time a specific program is developed and implemented for the client. The Committee suggests that every effort be made by the Division of Vocational Rehabilitation to reduce "red tape" when it is using the intake service of other agencies. This would encourage prompt cooperation in scheduling clients. Efforts should be made to purchase intake services from those who will cooperate with the rehabilitation agency and who will schedule and promptly report information needed by the counselor to develop the program. Consideration should be given as to whether certain types of programs might be initiated prior to receipt of formal written reports on an immediate provisional basis.

The Committee feels that the Division of Vocational Rehabilitation should take the initiative with other agencies to attempt to develop a standardized biographical and test data form to expedite the intake process. This would permit several public and/or private agencies seeing and working with the same family to be spared the expense and time of reinterviewing, testing, and so forth, as the basic information could be provided to all of the agencies needing it.

> THE COMMITTEE RECOMMENDS THAT ALL AGENCIES WORKING IN THE AREA OF REHABILITATION DEVELOP A STANDARD FOLLOW-UP REPORT FORM. THIS ASSUMES THAT EACH AGENCY WILL TAKE THE RESPONSIBILITY OF COMMUNICATING FINDINGS AND ACTION TO THE REFERRING AGENCY.

> THE COMMITTEE RECOMMENDS THAT THE DIVISION OF VOCATIONAL REHABILITATION UNDERTAKE A STUDY TO DETERMINE THE FEASIBILITY OF A COMMON INTAKE FORM, SIMPLE IN STRUCTURE, YET SUFFICIENTLY COMPREHENSIVE TO REFLECT THE HISTORY OF THE CLIENT'S CONTACT.

To expedite the rehabilitation process the Committee feels that the use of the above common intake and follow-up forms will facilitate service and provide effective follow-up.

> THE COMMITTEE RECOMMENDS THAT IT BE PRESUMED THAT THE CLIENT IS ELIGIBLE WITH COUNSELING AND EVALUATIVE SERVICES COMMENCING, AS FEASIBLE, AT THE INITIAL CONTACT. DURING THIS TIME REQUIRED HISTORY AND OTHER PERTINENT EXAMINATIONS CAN BE ARRANGED FOR.

Comprehensive Evaluation for Services

Comprehensive or multi-discipline evaluation on a team basis is now available at several locations in the Region. Thorough and complete evaluation is extremely important in determining whether rehabilitation services will be offered and to determine the type of program needed to reach the employment goals. Good comprehensive evaluation is the key to successful rehabilitation and should be emphasized in program development.

> THE COMMITTEE RECOMMENDS THAT SUFFICIENT COMPREHENSIVE EVALUATION PROGRAMS BE DEVELOPED IN THE REGION, OR EXISTING ONES EXPANDED SO THAT EVALUATIONS CAN BE SCHEDULED PROMPTLY AND PERFORMED THOROUGHLY.

Service Programs - Multi-Disability versus Single Disability

The early pattern of program development in this state for serving the disabled was primarily in the field of developing facilities which serve a single or limited range of disabilities. Although this pattern has been changing in recent years, there still exists in the state today many of this type, primarily for the blind, cerebral palsied, mentally retarded, and for narcotic and alcohol addiction. Considering efficient personnel utilization, the manpower shortage, and the high cost of providing personal services related to vocational rehabilitation, it is extremely important that the maximum amount of service and utilization be achieved in these service programs. It should be recognized that the incidence of a given disability in a population may, in many instances, be too small to justify a facility serving one group whereas a multi-disability facility could be justified. It should also be recognized that multi-disability centers will have to acquire adequately trained professional staff to properly service those disability groups.

> THE COMMITTEE RECOMMENDS THAT PROGRAMS WHICH RELATE TO SINGLE DISABILITIES BE ENCOURAGED WHENEVER POSSIBLE, TO EXPAND SERVICES TO INCLUDE OTHER DISABILITIES, OR TO DEVELOP A PROGRAM IN CONJUNCTION WITH OTHER PROGRAMS OR FACILITIES WHICH RESULTS IN SHARING CERTAIN PROFESSIONAL PERSONS OR SERVICES.

Service Programs - Community versus Regional

It is important that a distinction be drawn between those facilities which primarily serve a regional or multi-county area as compared to facilities which identify almost completely with a given community. Programs which identify with a given community should obtain a high level of financial and business support from the community. These facilities, to operate efficiently, will generally need to serve a range of disabilities and provide a variety of rehabilitation services.

Programs offered under a regional or multi-county facility, on the other hand, will usually have more difficulty in attracting financial and business support outside of their immediate community. Distinction needs to be developed between those programs which essentially extend beyond the community in which they are located and/or render services which either support community programs or education. The service spectrum in a given facility is such that certain services may be community oriented and others may have a regional orientation.

> THE COMMITTEE RECOMMENDS THAT GOVERNMENT FINANCIAL SUPPORT OF FACILITIES BE SUFFICIENT TO ASSURE THAT QUALITY PROGRAMS CAN BE CONTINUED AND NEW PROGRAMS AND SERVICES INSTITUTED AS THE NEED ARISES.

Master Planning for Vocational Rehabilitation Services

Long range planning to promote the best utilization of existing services and the development of future services of all types has been generally accepted in New York State. It is equally important that this concept be readily accepted for vocational rehabilitation services. This includes planning coordination with all other government agencies and with the many voluntary organizations and facilities in the state. There are many other planning groups in the state and in some areas these planning groups will overlap certain phases of rehabilitation planning. There should be, therefore, a high level of coordination among the groups. Adequate planning should be done on all levels to reduce duplication of services and to encourage maximum utilization of manpower. Adequate advisory groups should be established to consult and advise state officials who are responsible for planning and implementation of service programs.

> THE COMMITTEE RECOMMENDS THAT THE STATE DIVISION OF VOCATIONAL REHABILITATION SHOULD BE GIVEN THE RESPONSIBILITY IN THE STATE FOR COORDINATING THE DEVELOPMENT OF A MASTER PLAN RELATING TO ALL ASPECTS AND ALL TYPES OF REHABILITATION SERVICES IN THE STATE.

Size and Expansion of Services

The size and expansion of service programs must be considered to reach a level of service where all manpower and economic factors favor program continuity. When programs reach optimum sizes, consideration should be given to establishing or expanding other programs which might better relate to the home location of the disabled to be served or to the community or business interests which are involved in the successful rehabilitation program.

> THE COMMITTEE RECOMMENDS THAT THE STATE DIVISION OF VOCATIONAL REHABILITATION SHOULD WORK WITH FACILITY PROGRAMS TO DEVELOP CRITERIA WHICH EFFECTIVELY EVALUATE THE PROGRAM AND FACILITY EXPANSION WHICH MIGHT BE REQUIRED.

Program Standards

Standards which could be used to evaluate programs and the quality of the facility to render certain services are limited. The State Division of Vocational Rehabilitation has previously had a standards program which could be applied to workshops for which grants were being considered. Such standards as related to programs which have been developed by the New York State Department of Health have been utilized in recognizing other rehabilitation programs. The accrediting program of the Commission of Accreditation for Rehabilitation Facilities should be considered as one of the possible applications of standards for service.

> THE COMMITTEE RECOMMENDS THAT STANDARDS TO APPROVE ALL TYPES OF REHABILITATION PROGRAMS BE DEVELOPED.

Location of Services

Region III, as shown in earlier sections, covers a large geographic area. The population and incident of disability in a given geographic location is too small in many instances for effective service programs to be established or operated. However, it is important whenever possible to provide services near the residence of the persons to be served.

> THE COMMITTEE RECOMMENDS THAT WHEREVER FEASIBLE, THE CONCEPT SHOULD BE CONSIDERED THAT SERVICES SHOULD BE ESTABLISHED AS CLOSE TO THE RESIDENCE OF THE DISABLED AS POSSIBLE.

Residences for Disabled

Residences for the disabled may be a major factor in reaching vocational rehabilitation objectives. They may be an important factor while clients are receiving rehabilitation services. The utilization patterns of various facilities should be a major factor in determining the number, location and type of residences required. Continuous effort must also be made to promote the availability of adequate residences for the disabled engaged in sheltered or competitive employment. The residence factor coupled with possible transportation problems, may, in many instances, become the overriding factor in establishing realistic vocational rehabilitation objectives. The Division of Vocational Rehabilitation should accept the leadership role to provide coordination with other government agencies as well as the voluntary sector in providing solutions to this problem.

> THE COMMITTEE RECOMMENDS THAT REHABILITATION FACILITIES SHOULD BE ENCOURAGED AND HELPED, ON A SELECTED BASIS, TO PROVIDE ADEQUATE RESIDENCES FOR THE DISABLED WHILE THEY ARE PARTICIPATING IN VOCATIONAL REHABILITATION PROGRAMS.

Directory of Services

There is currently no complete central identification of available service programs in New York State. A beginning of such identification has been made by the Bureau of Facility Planning in the State Division of Vocational Rehabilitation. Information should be available to all government and voluntary agencies in the state. Such a program should be on an informational basis. It should not be developed as an accreditation program, nor serve as an indication of government agency approval of a program.

> THE COMMITTEE RECOMMENDS THAT THE STATE DIVISION OF VOCATIONAL REHABILITATION IN CONJUNCTION WITH THE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED DEVELOP A PUBLICATION, UPDATED EVERY TWO YEARS, IDENTIFYING REHABILITATION SERVICE PROGRAMS WHICH EXIST IN NEW YORK STATE FOR ALL TYPES OF DISABILITIES.

Expansion of Services to Those not Previously Served

Recent changes in legislation indicate that the socially and culturally disadvantaged, a group not previously served to any large degree by the traditional vocational rehabilitation programs, are now eligible for certain services offered by the state vocational rehabilitation agencies. The other group not served in large numbers in the past is the severely disabled. The expansion of services to these groups can be expected to result in higher per unit costs and a strain on manpower.

Services should be gradually expanded to all groups who can benefit from rehabilitation service programs and, who, because of these programs, reach sheltered or competitive goals. This expansion must be gradual and planned so it will not disrupt existing services or reduce their quality. The major factors in this expansion will be manpower availability and financing.

The amount, type, size and effort by the rehabilitation services for the severely disabled and the disadvantaged must be carefully studied and implemented on a wide basis only after demonstration projects have been successfully completed. Limited manpower and financial resources must also be considered. Programs, for these disabled should be implemented on the same gradual basis as the programs to serve other disabled are expanded.

> THE COMMITTEE RECOMMENDS THAT BECAUSE OF LIMITED FUNDS AND MANPOWER, THE MAJOR STATE VOCATIONAL REHABILITATION EFFORT BE APPLIED TO THOSE IN NEED OF REHABILITATION WITH CAREFUL PLANNING WITH THE PUBLIC AND VOLUNTARY AGENCIES TO EXPAND SERVICES FOR THE DISADVANTAGED AND SEVERELY DISABLED.

Services for Young Children and Families of the Handicapped

Discussion in a number of districts indicated preventive work could be done through the schools with young children.

> THE COMMITTEE RECOMMENDS THAT EFFORTS BE MADE TO IDENTIFY SCHOOL-AGE CHILDREN WHO MIGHT POSSIBLY NEED VOCATIONAL REHABILITATION SERVICES IN THE FUTURE. EFFORTS SHOULD BE MADE TO PROVIDE APPROPRIATE SERVICES TO THESE CHILDREN DURING SCHOOL YEARS WHICH WOULD REDUCE OR ELIMINATE THE NEED FOR SERVICES AT A LATER TIME.

The Committee also discussed the need to extend services to families of the handicapped. It was noted and believed that in many instances successful rehabilitation programs may hinge completely on solution of a multitude of problems which may exist in the family of the handicapped person. This includes the home environment and interrelationships of various family members.

> THE COMMITTEE RECOMMENDS THAT SERVICES TO FAMILIES BE INCLUDED IN THE VOCATIONAL REHABILITATION PROGRAM OF A CLIENT WHEN SUCH SERVICES HAVE AN IMPACT ON AND WILL INFLUENCE THE SUCCESSFUL OUTCOME OF THE CLIENT'S REHABILITATION.

Services for Prison Populations

Vocational Rehabilitation services should be available to inmates of the state and local prisons. The Division of Vocational Rehabilitation and Commission for the Blind and Visually Handicapped should develop services in conjunction with prison authorities. The program should include placement work with those nearing release. Vocational counselors would serve prisoners directly and work in conjunction with prison authorities. In developing such a program, strong consideration must be given to the use of community facilities and their interrelationship to a successful rehabilitation program. Consideration should also be given to establishing job training programs, work adjustment training programs, and personal adjustment training programs as components of the vocational rehabilitation service.

> THE COMMITTEE RECOMMENDS THAT THE STATE REHABILITATION AGENCIES AND OTHER APPROPRIATE AGENCIES COOPERATIVELY DEVELOP VOCATIONAL REHABILITATION PROGRAMS IN CORRECTIONAL INSTITUTIONS AND COMPLEMENTARY PROGRAMS FOR THOSE RELEASED TO THE COMMUNITY.

Services for the Blind

In Region III, there are four agencies serving blind persons and two workshops providing rehabilitation services.

In District I, the Albany Association of the Blind, a voluntary agency, has expanded rehabilitation services to the blind including low vision screening, rehabilitation teacher services, mobility training and social casework services. This agency has received a technical consultation grant to develop a regional comprehensive facility to serve the counties in its service area beginning July 1, 1969. This will enable blind persons to have comprehensive vocational rehabilitation services near their homes. Blind persons were previously required to travel to Syracuse or New York City for diagnostic and vocational evaluation.

In District II, Gateway Industries will provide terminal employment for blind persons who are residents of Ulster County and need sheltered employment. This agency is willing to develop a program to meet the needs of the blind in its service area.

In District III, the Blind Work Association, Inc. will expand sheltered shop employment. It will add homemaker services to its program, but will not expand to provide comprehensive vocational rehabilitation services.

In District IV, the Central Association for the Blind, Inc., will continue to provide sheltered shop employment. The comprehensive rehabilitation facility community plan for Onondaga County is as follows:

Upstate Medical Center will continue to provide diagnostic evaluation;

Consolidated Industries will provide vocational evaluation, pre-vocational evaluation, work conditioning, sheltered shop placement, and placement in industry;

Syracuse Association of Workers for the Blind, Inc. will provide mobility and homemaker services.

THE COMMITTEE RECOMMENDS THAT A REHABILITATION CENTER AND WORKSHOP BE DEVELOPED TO PROVIDE SERVICES FOR THE BLIND IN DISTRICT V AND THAT THE FOLLOWING PRIORITIES FOR THE BLIND BE ESTABLISHED:

1. A comprehensive rehabilitation facility in Albany to serve ten counties initially - Albany, Rensselaer, Schenectady, Green, Schoharie, Saratoga, Warren, Washington, Clinton, Essex.

2. Development and expansion of the existing workshop facility in Utica to provide vocational evaluation for blind persons.

3. Utilization and development of services and employment in generic workshops south of the Canadian Border - Plattsburgh, Watertown, and Glens Falls - to serve blind persons.

4. Further development of homemaker service throughout the Region to provide services to blind persons directly where there are no agencies for the blind. There should be a rehabilitation teacher of the Commission for the Blind and Visually Handicapped to provide this service.

5. Provision of transient residences and transportation for blind persons in rehabilitation programs.

Analysis for Future Facilities

The Rehabilitation Facility and Workshop Planning Project and the Office for Comprehensive Statewide Planning for Vocational Rehabilitation Services developed the following list for additional services which their analysis shows are needed.

County	What is Needed	Location
Clinton	Primary Center(1), Blind Agency Counselor	Plattsburgh
Franklin	Satellite(2)	Malone, Tupper Lake, Saranac
St. Lawrence	Office, Facility Satellite	Potsdam, Ogdensburg
Jefferson	Primary Center	Watertown
Lewis	Office (Watertown)	Lowville
Hamilton	Develop Camp Sites	

---

(1) A primary center is a medical facility functioning in a regional area and providing comprehensive services. It includes vocational evaluation and adjustment programs.

(2) A satellite provides evaluation and sheltered placement. A team can move from the rehabilitation center to the satellite which is attached to the center. The team may make periodic visits to the satellite to provide professional services. If any client requires any major professional services, he is moved back to the home rehabilitation center and provided with such services until he is capable of returning to the satellite.

County	What is Needed	Location
Essex	Satellite (from Glens Falls or Plattsburgh)	Ticonderoga
Warren	Blind Services Expanded - Satellite (from Tri-Cities area)	Glens Falls
Washington and Saratoga	Satellite	Schuylerville
Montgomery and Fulton	Office - Center Johnstown, Gloversville, Amsterdam	Canajoharie
Schoharie	Satellite	Cobleskill
Rensselaer	Center	Menands
Albany Schenectady	Multi-Service Centers, Expansion of Comprehensive Blind Services	Albany, Schenectady, Troy
Greene	Satellite	Greenville
Columbia	Satellite	Hudson
Dutchess	Multi-Service Centers, Model City, Expanded Blind Services - Satellite	Poughkeepsie, Beacon
Orange	Workshop	Middletown
Ulster	Expansion of Workshops, Including Blind - Satellite	Kingston
Putnam	Multi-Service Center - Satellite	Brewster
Sullivan	Workshop	Monticello
Broome	Primary Center and Satellite	Binghamton.
Delaware	Office	Walton
Otsego	Multi-Service Center and Workshop	Oneonta
Tioga	Satellite	Owego
Cortland	Multi-Service Center and Satellite	Cortland
Chenango	Satellite	Norwich
Oswego	Satellite	Fulton
Cayuga	Workshop	Auburn
Madison	Satellite	Morrisville
Oneida	Multi-Service Center, Workshop, Blind Facility	Utica
Onondaga	Multi-Service Center - Comprehensive Center	Syracuse

The Committee feels every consideration should be given to the above recommendations.

Demonstration Projects

Project I

Counties, although maintaining some political identity, are losing significance as natural service areas. Planning, development, and delivery of services are increasingly done on a more regional basis, and there-

fore there is a need for an interagency coordinating council on a local level to provide a mechanism for more efficient and effective service for people living in a service area. Such a council would be composed of representatives from public and private agencies and would assume the responsibility for coordination and research, but without a direct service role.

It is felt that the development of a coordinating council in a community requires structure, responsibility, and funding. In the experience of the Committee most community councils are limited in their capacity to coordinate facilities and services. It is felt that studies on a demonstration basis should be developed to insure the ultimate establishment of effective councils.

The council could, as a beginning, address itself to the following:

Given the fact that programs for social services have proliferated, how might these services be coordinated or developed in order to serve more people better?

Studies reveal that there is a high incidence of disablement in minority and deprived groups. Why are so few reached? How can they be reached?

Capitalizing on the initial motivation of the individual is essential for successful rehabilitation to occur. Are there delays in servicing clients? If so, what might be done to speed up the process?

The Division of Vocational Rehabilitation and the Commission for the Blind and Visually Handicapped depend on the community to provide services for their clients. Are combinations of services possible which could serve the community better?

How can commerce, industry, labor, and education form a partnership in the community and service agencies to successfully place the handicapped into the work force?

Transportation of clients to services is a statewide problem. How might this be overcome?

Shortages both in technical and professional manpower exist in the vocational rehabilitation field. What approaches might be taken to better utilize existing and potential manpower?

How might better communication and interagency relationships be established?

Given alternate recommendations for changes in service to the handicapped, what priorities should be established for legislation, manpower, funding?

Is there a need for one agency to be responsible for over-all fact-finding, either in respect to the population served or the types of services rendered? If so, what agency should be responsible and how might this be implemented?

DISTRICT I RECOMMENDS DEVELOPMENT OF A COORDINATING COUNCIL ON A DEMONSTRATION BASIS, WITH THE HOPE THAT THE RESULTS OF SUCH AN EFFORT COULD THEN BE TRANSLATED THROUGHOUT THE STATE.

Project II

During the course of their study several documents came to the attention of the District I Committee. One was a release of a paper discussing the neighborhood center concept written by Michael S. March, Assistant to the Chief of the Education Manpower and Science Division in the U. S. Bureau of the Budget, Executive Office of the President. This document discusses the neighborhood center as an organization for delivering a broad range of social services in a coordinated and responsive manner to individuals and families, and for serving the neighborhood at large. The principal focus is on the service delivery system with co-location of various agencies and services in a single building or a social service plaza, integration of the services through central administration, and with core services viewed as an essential part of the overall system concept. The second document was the Kerner Report which stressed the urgent need to serve the disadvantaged more rapidly and efficiently. The Report gives impetus to the urgency of developing coordinated services in urban areas. Thirdly, the Committee was aware of the material developed by Robert Reiff and Frank Reissman in The Indigenous Nonprofessional. They discuss a close, emerging relationship between such a center as they propose and the community. The authors view this close relationship with the "nonprofessional" peer as perhaps the most effective way of reaching and involving the poor. It provides a "human link" to the professional services and makes possible new kinds of programs which are better designed for those who need them and therefore better utilized by them. The authors suggest that possible ways of using indigenous nonprofessionals in community action and mental health programs are numerous and that to the indigenous nonprofessional, "helping others" is a reciprocal process. He may need help someday himself and may, therefore, believe that the very people he is serving may then perform the same service for him. This is another underlying quality in his motivation. The poor often seem more willing to help each other in a personal way. It may be the very fact that the help each can give is so limited or it may be that they have no alternative, but they are quick to open their doors to family friends and neighbors, not simply on the reciprocal basis described, but because they know or remember how it feels to be helpless. This is the crucial difference in the involvement of the indigenous nonprofessional. Helping others is not a means of self actualization as it is with professionals. It is practical, sensible, concrete, quid pro quo relationship.

After discussing these materials, the Committee felt that a multi-service center might be one tool that would enable more disadvantaged and disabled people to be served close to their residence using indigenous people as part of the staff. The Committee felt that socio-diagrams have demonstrated the fact that multiproblem families find it difficult to seek out the various agencies which can serve them. When a family is referred to one or more agencies, the distance in reaching the other agencies is often great and the travel costly and time consuming. Different agencies' eligibility standards for service frequently delay service to the individual. Usually only one member of the family is served, leaving the rest of the family problems unresolved.

The much-discussed proliferation of programs which has been created by local, state and federal agencies has led to fragmentation and compartmentalization. There exists today, at all levels, a lack of communication and inter-agency relationships. Many agencies have overlapping responsibilities for rehabilitating the people they serve, and as a result many people are lost between agencies. It is imperative that the restructuring and reshaping of service delivery systems have high priority in order to reach the disabled who are now being served, and to serve more adequately those who are known to agencies.

One tool for this type of service is a multi-service center. It will require decentralization of services into the disadvantaged areas, co-location of service components, and integration of services. Involvement of the disadvantaged in the service area is important to the success of such a center. They can be employed as subprofessionals thus serving as a source of manpower, as a bridge between the center and the community, and as future professionals if they are given supervision and training. They may also be involved in the planning of services, thereby keeping the center aware of the needs of the community. The Committee envisioned such a service agency as providing evaluation and vocational rehabilitation services, and serving as a coordinator for all the services which are required to meet an individual's needs. The Committee felt that the Division of Vocational Rehabilitation would be the most appropriate agency in New York State to administer such a project since it has a long and successful history in working for the total rehabilitation of its clients.

> THE COMMITTEE RECOMMENDS THAT A NEIGHBORHOOD MULTI-SERVICE CENTER SERVING THE TOTAL FAMILY BE DEVELOPED ON A DEMONSTRATION BASIS IN REGION III BY THE DIVISION OF VOCATIONAL REHABILITATION.

MANPOWER

Leadership Roles

In all areas which relate to service programs, there appears to be increasing problems in providing services because of the shortage of professional manpower. A multi-discipline approach is needed in the spectrum of agencies providing vocational rehabilitation services.

> THE COMMITTEE RECOMMENDS THAT THE DIVISION OF VOCATIONAL REHABILITATION AND THE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED ASSUME THE LEADERSHIP ROLE AT THE STATE LEVEL IN DEVELOPING SOLUTIONS TO THE MANPOWER PROBLEM AS IT RELATES TO THE OVERALL REHABILITATION FIELD.

No comprehensive survey has been undertaken in the state to determine the current manpower shortages and disciplines related to vocational rehabilitation services or to develop estimates of future manpower needs to staff new services or expanded programs.

> THE COMMITTEE RECOMMENDS THAT THE DIVISION OF VOCATIONAL REHABILITATION IN CONJUNCTION WITH THE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED CONDUCT A MANPOWER SURVEY TO DETERMINE CURRENT MANPOWER NEEDS IN THE AREA OF REHABILITATION AND ESTIMATE FUTURE NEEDS. THIS SURVEY SHOULD BE UPDATED EVERY TWO YEARS AND BE MADE AVAILABLE TO EDUCATORS, AND INTERESTED STATE AND NATIONAL ORGANIZATIONS DEALING WITH REHABILITATION MANPOWER PROBLEMS.

Many disciplines are involved in providing effective rehabilitation services. Currently, most of these require college education and an increasing number now require graduate training at the masters and doctoral levels. The disciplines which play an important role in the rehabilitation spectrum include the following:

Discipline	Training Level	State Licensure
Rehabilitation Counselor	Masters	No
Psychologist	Doctorate	Yes
Social Worker	Masters	No
Rehabilitation Administration	Masters	No
Workshop Supervisor	(Not defined)	No
Placement Counselor	Bachelors	No
Psychiatrist	Doctorate plus special	Yes
Physiatrist	Doctorate plus special	Yes
Physical Therapist	Bachelor	Yes
Occupational Therapist	Bachelor	No
Speech Therapist	Masters	No
Rehabilitation Nurse	Masters	Yes
Vocational Evaluator	Bachelors plus special	No
Prosthetist	Special	No
Orthetist	Special	No

Disciplines in addition to those mentioned above also play an important role in the rehabilitation process. Among these are teachers with special qualifications, doctors ranging from the general practitioner to specialist in many fields, audiologists, other allied health professions, etc. Organized efforts are underway to improve and coordinate efforts to resolve current manpower problems in some of these fields.

Qualification standards in nearly all of the disciplines mentioned now generally established by national organizations composed of the different disciplines involved. Even in instances where State Licensures exist, a national standard is basically accepted to determine entry qualifications for licensure examinations. During the past twenty years each of these disciplines has established itself as a profession.

In general, they cannot be expected at this time to consider reducing the training level required, or, within a short period of time, to establish such specialities within their disciplines which require lower training levels.

Role of the State University

During this decade, there has been a major expansion of the State University of New York throughout the state. Commendably, a number of programs in the rehabilitation field are now offered by the State University system. An analysis of manpower needs should be a basis for planning in the State University system to provide an increase in the training programs to meet manpower requirements. The State University should assume a leadership role in defining and developing rehabilitation disciplines which reduce the amount of training required to meet certain rehabilitation needs. If such manpower areas can be defined, the State University system through its Community College program has an excellent method of implementing programs. The State University system should also be encouraged to utilize its resources and accept feasible research and demonstration projects which could contribute to improved programs of vocational rehabilitation.

> THE COMMITTEE RECOMMENDS THAT THE COMMISSIONER OF VOCATIONAL REHABILITATION AND THE DIRECTOR OF VOCATIONAL REHABILITATION SERVICES FOR THE BLIND AND VISUALLY HANDICAPPED SHOULD ASSUME A LEADERSHIP ROLE IN INTERPRETING TO THE CENTRAL OFFICE OF THE STATE UNIVERSITY SYSTEM MANPOWER NEEDS AS THEY RELATE TO VOCATIONAL REHABILITATION PROGRAMS IN THE STATE.

Recruitment

Many young men and women today begin to formulate their plans for careers before they reach their senior year in high school. Many professions make an organized effort to provide information through a vocational guidance counselor located in schools and through other methods to foster career interest in their respective fields. The New York State Health Department now has a Division on Health Manpower which is planning in this direction.

> THE COMMITTEE RECOMMENDS THAT LEADERSHIP IN THE STATE BE UNDERTAKEN BY THE DIVISION OF VOCATIONAL REHABILITATION IN CONJUNCTION WITH THE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED TO DEVELOP AND DISSEMINATE THROUGHOUT THE STATE APPROPRIATE MATERIAL AND INFORMATION WHICH WILL FOSTER INTEREST IN REHABILITATION CAREERS.

It should be possible to launch new efforts at securing personnel from currently untapped resources. Specifically, attention should be paid to utilizing personnel drawn directly from inner city neighborhoods to serve as community aides, and developing mid-career training programs in vocational rehabilitation to encourage women to return to the work force after family responsibilities have lessened.

Aids should be developed which will be available to assist rehabilitation facilities in the State in their recruitment efforts. Consideration should be given for development of summer work experiences in rehabilitation programs for high school students or undergraduate college students which would promote entry into a vocational rehabilitation career. Another possibility for adding additional manpower to the field and building interest in rehabilitation careers is recruitment through variations of college work-study programs. A number of these programs in various sections of the East now exist in certain curriculum areas. In these programs, students work part of the year and spend the balance of the year on campus studying toward degrees. This enables students to seek careers when it might not otherwise be possible because they must support themselves during the college years. In other programs, the work approach is on a one, two, or three-day basis throughout the academic program. Possibly some demonstration programs should be considered in selective rehabilitation career fields.

Expansion of Services versus Manpower Shortage

Nearly all agencies and facilities providing vocational rehabilitation services are now experiencing manpower shortages. It is recognized that as new programs are begun, and old programs are expanded, there will be insufficient staff to meet these new needs. This creates major problems. The turnover of staff in most programs and the time spent recruiting results in closing or reducing components of certain programs. This situation is most critical for agencies and facilities since most operational costs continue even though programs must be reduced. There is also the increased problem of "start-up" costs related to recruiting new staff and upgrading their performance.

The Committee feels very strongly that the Office of Rehabilitation should only expand its activities as fast as trained personnel is available. Too rapid expansion with lack of adequate professional staff will result in creating a time lag between the onset of the referral and the onset of service. The immediate goal must, of necessity, involve setting a priority on filling existing staff vacancies by using new staffing patterns and techniques. Coordination of service will aid this effort. As new professional staff are recruited and new techniques prove successful, then expansion of services can be undertaken.

> THE COMMITTEE RECOMMENDS THAT WHEN PROGRAMS ARE TO BE EXPANDED OR NEW PROGRAMS OFFERED, CAUTION SHOULD BE USED IN PROMOTING THESE DEVELOPMENTS SO THAT IT DOES NOT RESULT IN AN OVERALL NET LOSS. EFFORTS SHOULD BE MADE AT EVERY LEVEL TO ENSURE THAT EXISTING MANPOWER IS EFFECTIVELY AND EFFICIENTLY USED AND THAT ADDITIONAL MANPOWER IS BEING TRAINED TO MEET THE EXISTING NEEDS, AS WELL AS FOR NEW EXPANDED PROGRAMS.

Two factors are important in considering the location and distribution of staff. First, there currently is a loss of staff time in terms of traveling from district to sub-district office. Secondly, the Committee feels that the counselor living in the county becomes more aware of the services available, and the county becomes more familiar with the work and the abilities of the Office of Rehabilitation to serve handicapped people.

> THE COMMITTEE RECOMMENDS THAT THERE BE A DECENTRALIZATION OF REHABILITATION SERVICES WITH A MINIMUM OF ONE COUNSELOR ASSIGNED FOR EACH COUNTY OVER 40,000 POPULATION IN THE STATE AS SOON AS THIS BECOMES FEASIBLE.

Restructuring Personnel Positions

The current practice in the rehabilitation field is to draw upon counseling disciplines for supervisory and administrative personnel, and salary scales are tied to this kind of promotion. This compels the counselor to seek upgrading to the administrative level for salary reasons, even though he may be most capable in the counselor role. The complexity of vocational rehabilitation is such that administration of the programs should be considered a different, although related, professional skill.

> THE COMMITTEE RECOMMENDS THAT A SPECIFIC STUDY BE DESIGNED THAT WOULD EXAMINE IN DETAIL THE CURRENT ROLE AND TASK FUNCTIONING OF REHABILITATION COUNSELORS WITH THE OBJECTIVE OF SEPARATING ADMINISTRATIVE AND SERVICE FUNCTIONS AT BOTH THE PROFESSIONAL AND SUPPORT-PERSONNEL LEVELS.
>
> THE COMMITTEE RECOMMENDS THAT PROFESSIONAL ADMINISTRATORS IN ADDITION TO THE DISCIPLINE OF REHABILITATION COUNSELING CAN ALSO BE UTILIZED TO ADMINISTER AND SUPERVISE PROGRAMS.

Support Staff

At present, use of supportive staff in many instances is restricted by the standards of a given profession, by practice, or by various state and national regulations or laws. Every consideration should be given to utilizing supporting staff in all areas of vocational rehabilitation services. Support staff may take the form of personnel who require less formal training to render a component of service in a given program. They may also perform certain administrative duties so that the professional staff members can devote a larger amount of time to providing direct service.

> THE COMMITTEE RECOMMENDS THAT THE STATE DIVISION FOR VOCATIONAL REHABILITATION IN CONJUNCTION WITH THE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED SHOULD PROMOTE FINANCIAL SUPPORT FOR SUPPORT PERSONNEL IN THE SAME MANNER THEY ARE FUNDING PROFESSIONAL STAFF.

Volunteers

Programs in many other fields have effectively used volunteers. The cost incurred in utilization of volunteers should be considered as part of program costs. Training should be made available when possible and should also be considered as part of program costs.

> THE COMMITTEE RECOMMENDS THAT WHENEVER POSSIBLE VOLUNTEERS SHOULD BE USED IN REHABILITATION PROGRAMS.

Part-Time Personnel

The rehabilitation programs may, in many instances, be able to resolve manpower problems by utilizing several part-time persons to fill full-time positions. It should be recognized that many women are again available for employment when their children are of school age. Many former employees of the rehabilitation programs can be qualified with minimal reorientation to render valuable service particularly in part-time positions.

> THE COMMITTEE RECOMMENDS THAT REHABILITATION PROGRAMS BE ENCOURAGED TO USE PART-TIME PERSONNEL WHENEVER FEASIBLE. EFFORTS SHOULD BE MADE BY BOTH GOVERNMENT AND VOLUNTARY AGENCIES TO ENCOURAGE QUALIFIED COMMUNITY CITIZENS TO SEEK PART-TIME EMPLOYMENT IN THE REHABILITATION FIELD. ALL AVAILABLE MECHANISMS FOR RECRUITMENT SHOULD BE CONSIDERED.

Manpower for the Blind

In relating specifically to the needs of the blind, it is imperative that in future planning for rehabilitation service definite provision be made to train specialized staff to serve this disability group. It is important also that adequate supervision be given to personnel working with the blind and that the supervisors are persons who understand the problems of blindness. It has been indicated that there is difficulty attracting adequate numbers of rehabilitation counselors who are qualified to work with the blind. It is important that an additional effort be made to interest enough qualified personnel to enter this field. Aides or assistants to professional staff working with the blind should also have special orientation to acquaint them with the special rehabilitation problems which the blind person poses.

Support of Training

In a number of rehabilitation career fields, it is realized that training in the state may not be sufficient to accommodate all of the students who are qualified and desire to matriculate. Because of the critical manpower shortage in the rehabilitation field, students who are pursuing college careers in other states in the rehabilitation field, and who would be otherwise eligible for state assistance during their education should be given the same assistance during their out-of-state education. This should be contingent to some degree on the student's return to New York State to work following graduation.

> THE COMMITTEE RECOMMENDS THAT OUT-OF-STATE TRAINING IN REHABILITATION DISCIPLINES BE RECOGNIZED BY NEW YORK STATE FOR CERTIFICATION OR LICENSING PURPOSES WHEN NATIONAL STANDARDS ARE MET, OR DEVIATIONS FROM STATE STANDARDS ARE MET, OR DEVIATIONS FROM STATE STANDARDS ARE MINIMUM.

There are a limited number of stipends available to universities offering programs in vocational rehabilitation. Many students who could enter this program are eliminated because of the competition due to limited funds.

> THE COMMITTEE RECOMMENDS THAT THE STATE REHABILITATION AGENCY SEEK AN EXPANSION OF GRANTS FOR EDUCATION OR UNDERWRITE THESE GRANTS TO THE EXTENT THAT FUNDS ARE AVAILABLE.

Clinical Training Programs

As part of their education for all rehabilitation disciplines, it should be required that affiliations be established for clinical training with facilities which provide rehabilitation services. Both public and voluntary rehabilitation facilities should be encouraged, when their programs permit, to offer clinical training programs. Such participation may mean increased operating cost to the facility or a reduced work load for the time devoted to training of clinical trainees.

> THE COMMITTEE RECOMMENDS THAT THE STATE AGENCIES PURCHASING REHABILITATION SERVICES SHOULD DIRECTLY OR INDIRECTLY ASSIST IN SUSTAINING THE COST OF CLINICAL TRAINING PROGRAMS RELATED TO REHABILITATION DISCIPLINES.

Continuing Education

Continuing education may be defined as that education which is provided subsequent to formal education.

There are continual changes, improvements and new methods being introduced throughout the country today in nearly all the fields of rehabilitation. It is important that New York State rehabilitation personnel be kept abreast of these developments.

THE COMMITTEE RECOMMENDS THAT THE NEW YORK STATE DIVISION OF VOCATIONAL REHABILITATION IN CONJUNCTION WITH THE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED ASSUME THE COORDINATING ROLE IN PROMOTING CONTINUING EDUCATION IN REHABILITATION DISCIPLINES IN NEW YORK STATE. FUNDS SHOULD BE MADE AVAILABLE TO ASSIST REHABILITATION PERSONNEL TO OBTAIN THIS TRAINING AND ALSO TO INSTITUTIONS WHO WISH TO OFFER THIS TRAINING.

Re-Training

Individuals who have previously held positions in rehabilitation programs but who have been out of the employment market for a number of years may hesitate to seek re-employment because they feel changes in the field have been too great. Since this group would consist primarily of housewives, it would be important that this training be close to their homes, probably offered on a one- or two-day per week basis. If this training could not be offered in the larger facilities, it would be possible to offer such training in mobile units if adequate transportation is provided, thus permitting housewives to attend. Another group which might be effectively utilized would be retired persons, including teachers.

THE COMMITTEE RECOMMENDS THAT ADEQUATE PROGRAMS BE ESTABLISHED IN THE STATE TO OFFER REFRESHER COURSES TO THOSE WHO WOULD BE WILLING TO RETURN TO FULL OR PART-TIME EMPLOYMENT IN THE REHABILITATION FIELDS.

Salaries

Compensation in many rehabilitation fields does not compare favorably with private industry. While it was noted that during the past five years there has been a regular upward movement of salaries, it is still felt that salaries in general do not close this gap. It is important that every effort be made to close this salary gap at as early a date as possible. Persons considering rehabilitation careers usually study salary patterns in making career selections. How individuals choose rehabilitation careers depends on many factors, but economic factors are extremely important, particularly among males who must support families. Salary problems also exist in this respect in retaining adequate personnel for service as compared to administrative levels. Many males who render outstanding service to clients subsequently seek administrative positions because of economic needs of their families even though they might prefer not be become administrators.

THE COMMITTEE RECOMMENDS THAT PAY SCALES FOR COUNSELORS BE COMMENSURATE WITH THEIR SKILL AND CAPACITY FOR INDEPENDENT FUNCTIONING AS A MEANS OF UPGRADING WITHOUT THE NECESSITY FOR THEIR SEEKING SUPERVISORY AND ADMINISTRATIVE POSTS.

Small facilities and facilities in remote locations tend to have the most difficulty in meeting manpower needs. Current experience is that many of these require only one full-time, or in some instances, part-time, staff person in a given discipline to effectively operate programs. When one program component leaves the facility or is not available, this has a major effect on the agency's ability to render service. Usually recruitment is extremely difficult in this situation. Solutions to this problem, particularly as it relates to personnel working in less desirable geographic areas of the state, hinges in major part on solutions to manpower shortages. It should be realized that in certain instances higher salaries may have to be paid to attract persons to these positions than would be paid in more centrally located or larger facilities. Adequate consideration should be given to this fact in providing payment for services.

Demonstration Projects

Emphasis on demonstration projects in the manpower field to determine in which fields the personnel of various training programs can best be utilized should be encouraged. Particularly, community colleges should be encouraged to work with community rehabilitation facilities to develop demonstration projects in this area.

5

ROLE OF GOVERNMENT AGENCIES

Evaluation of Relationships among Government Agencies

THE COMMITTEE RECOMMENDS THAT A SURVEY ANALYSIS OF THE VARIOUS ADMINISTRATIVE AGENCIES IN THE STATE GOVERNMENT BE UNDERTAKEN FOR THE PURPOSE OF BETTER ALIGNING THE STATE SYSTEM TO ACCOMMODATE COOPERATIVE RELATIONSHIPS BETWEEN THE FEDERAL HEALTH, EDUCATION, WELFARE DEPARTMENT AND NEW YORK STATE.

This analysis should be focused upon rehabilitation in light of services as defined under the 1965 Act as amended. The study should be extended to examine State and local relations in order to better align all services from the federal to the local level. This re-examination should be done from the base of operations in the Governor's Office and under the supervision of the appropriate officials concerned with research and planning in the development of long-term budget programs. The study's approach should not be departmentalized but undertaken from a perspective that provides an overview of total operations. The study should involve flexibility in approach to accommodate changes that will inevitably occur in Washington, and if possible should be undertaken cooperatively with the Department of Health, Education and Welfare. Study of the efforts of other states should be included, especially such experiments as undertaken in California. We see the need for consolidated authority and coordinated action among the state agencies and the need for clear distribution of power to the more local operative units in the state.

THE COMMITTEE FURTHER RECOMMENDS THAT IN ORDER TO ACHIEVE A MORE EFFICACIOUS AND EXTENSIVE DELIVERY OF SERVICES TO THE DISABLED, REGIONAL AGENCIES BE CREATED UNDER A STATE STRUCTURE WHICH WOULD BE RESPONSIBLE FOR COORDINATING THE EFFORTS OF BOTH PUBLIC AND PRIVATE AGENCIES IN THE FIELD OF REHABILITATION.

A further objective of the Regional Agency concept would be the encouragement of coordinated administrative rehabilitation programs, especially in those counties which have acquired jurisdiction over related programs such as those of health, mental health, welfare, and Community Chest and similar organizations.

THE COMMITTEE RECOMMENDS THAT PRIMARY EMPHASIS SHOULD BE GIVEN TO THE DEVELOPMENT OF COOPERATIVE EFFORTS AMONG PUBLIC AGENCIES, THE DEVELOPMENT OF SIMILAR INVOLVEMENTS AMONG PRIVATE AGENCIES, AND BETWEEN PUBLIC AND PRIVATE AGENCIES.

State Agencies Involved in Rehabilitation

Most state agencies are involved in some phase of rehabilitation services, although a number of these agencies do not have vocational rehabilitation as their only goal.

DEPARTMENT	DIVISION
Department of Education	Division of Vocational Rehabilitation Division for Handicapped Children
Department of Correction	
Executive Department	Division of Parole Division for Youth
Department of Health	Division of Medical Services Division of Preventive Services
Department of Labor	Division of Employment
Department of Mental Hygiene	Division of Mental Health Division of Local Services The Division of Mental Retardation
Department of Social Services	Division of Medical Services Division of Children's Services Division of Family Budget Commission for the Blind and Visually Handicapped

Rehabilitation is only one component of most of the agencies listed. There was considerable discussion in the Committee as to whether the rehabilitation components should be completely separated and consolidated into one state agency, or whether they should be left in existing agencies as program components.

The term "proliferation of services" has become a cliche and yet reality suggests that needs of all kinds have been met by instituting new programs. Although new ideas, new ways of work, and new funds often serve to challenge existing agencies to evaluate their programs, it is also true that competition arises for manpower, funds and authority. For example, the most successful programs of the Office of Economic Opportunity, "Headstart" and "Upward Bound," have stimulated the Education Department to take a look at their programs and who they are reaching. Other OEO programs have not been as successful and funds used to support these programs might better be channeled to existing agencies which have demonstrated expertise. Instant answers are not always the best solutions. Concern was expressed by the Committee that each agency has responded to a back-log of unmet needs by expanding its programs without consultation with other agencies.

It seems to the Committee that a beginning must be made to develop an orderly, coordinated, well publicized continuum of services which develop, maintain and sustain the client as an individual human being. There is a critical need to coordinate the programs serving disabled persons. There is at present no single coordinating agency. The "overview" approach to rehabilitation programs would assign manpower in a logical way where needed, would develop facilities to serve people close to their homes, and would dispense funds where needed. The Committee felt that the agency which could best assume this responsibility is the Division of Vocational Rehabilitation because it has a long history of providing service to meet the total needs of the client. It is in the best position to coordinate all of the programs which are currently serving individual needs in a fragmented manner.

There are examples of cooperation existing now between the New York State Division of Vocational Rehabilitation and other state agencies which contribute to or improve delivery of rehabilitation services to New York State residents. Strong coordination and cooperation between state agencies is extremely important for more efficient program delivery and for conservation of manpower and funds.

> THE COMMITTEE RECOMMENDS THAT AN OFFICE OF REHABILITATION IN THE EXECUTIVE DEPARTMENT BE ESTABLISHED TO COORDINATE AND BE RESPONSIBLE FOR ALL OF THE REHABILITATION PROGRAMS IN THE STATE, AND THAT THE POSITION OF COMMISSIONER OF THE OFFICE OF REHABILITATION BE ESTABLISHED WITH THE EXECUTIVE RESPONSIBILITY FOR SERVING AS THE CHIEF STATE AGENCY SPOKESMAN FOR ALL REHABILITATION PROGRAMS.
>
> One of the Commissioner's responsibilities should be to insure coordination of rehabilitation programs in the state among all the different agencies.
>
> THE COMMITTEE RECOMMENDS THAT AS THE BEGINNING OF COORDINATION OF SERVICES, THE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED BE TRANSFERRED TO A NEW OFFICE OF REHABILITATION WHICH WILL PROVIDE SERVICES TO ALL THE HANDICAPPED.
>
> The administrative organization of the Office of Rehabilitation should be such that special attention can continue to be given to the blind disabled including special field counseling. Continuing education should be utilized as the mechanism in training regular Division of Vocational Rehabilitation staff and to continue the education of the Commission for the Blind staff to do an increased amount of field work for the blind disabled. It is important that such a transfer be accomplished in an orderly manner which insures that rehabilitation serservices for the blind be continued at the same level and gradually expanded.
>
> THE COMMITTEE RECOMMENDS THAT A STUDY BE UNDERTAKEN TO DETERMINE THE FEASIBILITY OF MOVING THE MEDICAL REHABILITATION PROGRAM OF THE NEW YORK STATE HEALTH DEPARTMENT TO THE OFFICE OF REHABILITATION SINCE THIS PROGRAM PROVIDES VARIOUS REHABILITATION SERVICES TO PERSONS UNDER 21 OR IN THE CASE OF POLIOMYELITIS OVER 21.
>
> Since the advent of Medicaid, the program has increasingly served the more severely disabled. Such a move would ensure close coordination in providing rehabilitation services and subsequent vocational rehabilitation programs. It could also make it easier to develop programs where evaluation and identification of the disabled could be accomplished at an earlier age and would aid in planning early for vocational objectives. Early identification of handicapped children will lessen future vocational rehabilitation needs. The Committee feels that it is important to develop and intensify the school programs in order to engage in early identification and preventive programs before the handicap is either beyond help or very expensive to remedy.
>
> THE COMMITTEE RECOMMENDS THAT A STUDY BE CONDUCTED OF THE FEASIBILITY OF TRANSFERRING THE DIVISION OF HANDICAPPED CHILDREN IN THE NEW YORK STATE EDUCATION DEPARTMENT TO THE OFFICE OF VOCATIONAL REHABILITATION.

Research

As a result of a survey the Committee found that little rehabilitation research, formal or otherwise, has been contemplated, begun, or recently completed. The Committee feels that the Office of Rehabilitation should develop a "Data Bank" as a repository for information on the disabled, arranged so that combinations of information can be retrieved by various classifications. The Social Data Bank could be an extremely useful and efficient tool for routine review and evaluation of programs which are ongoing, and for identifying program gaps and program needs. It would permit the application of an efficient management method which is in use in many parts of the country by industry and business.

THE COMMITTEE RECOMMENDS THAT AS PART OF THE OFFICE OF REHABILITATION THERE SHOULD BE:

A PERMANENT RESEARCH BUREAU WHICH WOULD PROMOTE, ENCOURAGE AND FACILITATE RESEARCH IN THE ENTIRE VOCATIONAL REHABILITATION FIELD

A SIGNIFICANT INCREASE IN RESEARCH GRANTS AND A DYNAMIC PROGRAM WHICH WOULD ENCOURAGE SOUND RESEARCH IN SPECIFIC AREAS

A CLEARINGHOUSE FOR LOCAL, STATE, REGIONAL AND NATIONAL RESEARCH STUDIES

Coordination With Planning Groups

Planning for future services today has been accepted and implemented in many areas by government at all levels, and among voluntary groups. It is important that continual planning be a recognized component for future rehabilitation programs and services in the state. Such planning should be on an organized basis to give government agencies, voluntary providers of services, and consumers an opportunity to express views and make recommendations.

THE COMMITTEE RECOMMENDS THAT THE OFFICE OF REHABILITATION BE GIVEN THE RESPONSIBILITY FOR DEVELOPING PLANNING GROUPS IN THE STATE AND FOR COORDINATING THESE PLANNING GROUPS WITH OTHER STATE AGENCIES WHO OFFER REHABILITATION SERVICES.

Coordinating Council

With the multiplicity of governmental and voluntary agencies concerned with the handicapped, the importance of community planning and cooperation cannot be overemphasized. A competitive approach among the many agencies concerned frequently leads to inefficient use of available manpower and funds within a community. A cooperative approach through a central rehabilitation council should result in improved services to a larger number of clients who need them. A great need exists for agencies to understand one another's programs and services, and for the staffs of agencies to know one another. This means that agencies should release their staff for periodic meetings "around the table" with other agency staff. It is the Committee's observation that in several counties many agencies interpret their goals in different fashions creating problems in establishing and expanding services and coordinating them within the community. Local coordination has not been completely effective.

THE COMMITTEE RECOMMENDS THAT THE OFFICE OF REHABILITATION SET UP BASIC GUIDELINES FOR SERVICES FOR THE HANDICAPPED AND ACT AS A MEDIUM FOR DISCUSSION LEADING TO MORE EFFECTIVE COORDINATION OF THE REHABILITATION PROGRAMS OF THE LOCAL AGENCIES.

Vocational Rehabilitation Support Programs

New York State is unique in that it has developed several programs which support development and expansion of rehabilitation services throughout the state.

The Workshop Support Program provides grants for professional staff for the purpose of expanding or upgrading services in rehabilitation centers and sheltered workshops. In Region III it is obvious that a number of workshops have been able to reach an acceptable level of service or increase their client load largely because of the assistance from this support program. Expansion requires consultation between the state agencies and the representatives of the appropriate facilities in planning and providing services.

THE COMMITTEE RECOMMENDS THAT THE REHABILITATION WORKSHOP SUPPORT PROGRAM BE CONTINUED AND EXPANDED TO UPGRADE PROFESSIONAL STAFFING AND INCREASE SERVICE CAPACITY AND THAT CONSULTATION WITH THE ADVISORY COMMITTEE BE CONTINUED.

Rehabilitation Center Grants began when the Rehabilitation Committee of the New York State Interdepartmental Health and Hospital Council in 1960 developed a program to provide annual grants to support selected rehabilitation centers throughout the state. These grants ranged up to $50,000. Centers would be designated as Primary Centers or Secondary Centers. Primary Centers were to be designated in the geographic area of the major cities of the state. Secondary Centers were to be located in other geographic locations at distances exceeding 50 miles from the Primary Centers. A major component of these programs was to be provision of pre-vocational programs in the centers. Administration of these programs is delegated to the New York State Department of Health. Since the inauguration of this program a third center concept known as a Limited Rehabilitation Services Center has been added. These centers receive smaller grants which provide only the basic components of rehabilitation services.

Grants awarded have been continued each year and are intended to aid designated centers in increasing and improving rehabilitation services. In general, the services which improved have been in the medical rehabilitation sphere, although all of the Primary Centers and many Secondary Centers have added prevocational programs which were previously nonexistent. This program should be studied by utilizing the coordinating and advisory groups discussed earlier in this section. The terms Primary and Secondary Centers describe levels of services very close to that of certain Primary Centers. This terminology should be reviewed, with the idea of centers being identified as "Regional Centers" or "Community Centers". A factor to be considered in grant support programs should be clinical continuing-education programs conducted by the centers. Consideration should also be given to the addition of other centers which were previously ineligible due to geographic location. An approach to be considered would be similar to that which has been adopted in the workshop program by the Division of Vocational Rehabilitation. Another possibility is the combining of two types of programs at some point which would be in line with the new federal legislation. This legislation now makes no distinction between a rehabilitation center and sheltered workshop.

> THE COMMITTEE RECOMMENDS THAT RESPONSIBILITY FOR THE ADMINISTRATION OF THE REHABILITATION CENTER GRANT PROGRAM BE TRANSFERRED TO THE DIVISION OF VOCATIONAL REHABILITATION SINCE THAT DIVISION NOW HAS A FACILITIES PLANNING STAFF AND A FACILITIES ADVISORY COMMITTEE.

Other support programs involve a large percentage of federal participation. These programs in general are channeled through the Division of Vocational Rehabilitation and the Commission for the Blind and Visually Handicapped and relate to capital construction, expansion of service, or the establishment of new programs. The state should continue to provide adequate matching funds so that the state's share of federal allocated funds can be obtained each year. These programs have also had major impact in assisting state government and voluntary agencies in expanding and improving services over the years.

Evaluation of Agency Internal Operations

As the number of client referrals increases and as services rendered to clients becomes more complex, the volume of administrative work will also increase. Under such circumstances particular concern has been expressed by the Committee about the time it takes to process authorization for services to assure prompt payment. The fiscal backlog is a real problem for operating facilities with their limited budgets.

> THE COMMITTEE RECOMMENDS THAT THE DIVISION OF VOCATIONAL REHABILITATION AND THE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED EVALUATE NEWER ACCOUNTING METHODS AND DEVELOP A "METHODS AND PROCEDURE UNIT" CAPABLE OF SERVING AN EXPANDED PROGRAM.

Interstate Client Transfer

In general, no arrangements exist now between State Vocational Rehabilitation Agencies to permit interstate transfer of clients. Vocational Rehabilitation Agencies prefer to keep clients in their own state for service, although a facility in another state might be much closer to the client's home and might give him better service. The reasons are generally related to questions of funding and personnel. Few solutions have been advanced or tested to see if the service barriers created by state boundaries could be removed.

> THE COMMITTEE RECOMMENDS THE DEVELOPMENT OF A PROJECT DESIGNED TO STUDY SERVICE PATTERNS AS THEY ARE RELATED TO STATE BOUNDARY LINES. THE PROJECT SHOULD RECOMMEND NEW SERVICE PATTERNS.

Services to Mental Hygiene Facilities

The Committee feels that there should be an expansion in the assignment of rehabilitation counselors to state mental hospital facilities, community mental health centers, state schools, hospitals for the mentally retarded and other similar state facilities. Assignment of staff in these facilities in concert with appropriate facility staff would insure the development of a comprehensive vocational rehabilitation program for the clients in these facilities. Services should include diagnostic evaluation, vocational planning, pre-vocational training and adjustment, and placement. A vocational rehabilitation program could also be developed for the institutional population to enable these patients to make a better adjustment.

Expediting Referral

All district committees received reports of large time gaps between application for vocational rehabilitation service and the commencement of services. Some reports indicated delays for as long as five months, although information was not available to indicate what percentage of cases these reports represent. Suggestions for improvement ranged from the hiring of additional staff to the increased employment of specialists such as psychologists and physicians to expedite referral. Since bottlenecks in processing referrals may vary in different sections of the state, the Division of Vocational Rehabilitation should evaluate problems in each area and initiate appropriate steps to correct them. Particular attention should be paid to making sure that the client understands the referral procedure and time delay. Efforts must also be made to insure that the client is not "lost" between agencies during the time which lapses between referral and initiation of a definite vocational rehabilitation program.

> THE COMMITTEE RECOMMENDS THAT EVERY EFFORT BE MADE BY THE DIVISION OF VOCATIONAL REHABILITATION AND COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED TO EXPEDITE THE PROCESSING OF REFERRALS.

Placement Coordination

Placement is critical in many instances to successful vocational rehabilitation goals. Placement in many instances now results from efforts either individually or collectively by a selective placement service, the New York State Employment Service, state agencies, rehabilitation counselors, and/or personnel in rehabilitation facilities. It was noted that smaller facilities do not have the resources or the number of clients to justify a full-time placement director. It was also indicated that in many instances the employment offices are not located near enough to the facility to permit a close working relationship or selective placement. Counselors in these offices do not at present have sufficient time to work closely with the facility.

> THE COMMITTEE RECOMMENDS THAT THE DIVISION OF VOCATIONAL REHABILITATION AND COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED DEVELOP GUIDELINES WHICH WILL AID IN THE MORE EFFECTIVE PROVISION OF HIGH QUALITY PLACEMENT SERVICES.

Coordination of Services for Low Income Groups

The Committee felt that because low income groups often present complex problems, a concentration of services should be provided for these groups. One important criterion is adequate planning to prevent development of "crash" programs to meet pressing needs. Programs in many instances will need to be out-reach programs, as the people involved will not voluntarily seek service. Staff should be encouraged to develop liaison with community groups. This is an important factor for improving vocational rehabilitation opportunities. In the event the guaranteed income of family allowance programs become a reality, caseworkers from the Department of Social Services could be reoriented to accomplish various vocational rehabilitation goals. The Office of Rehabilitation should coordinate such an undertaking and provide appropriate training.

> THE COMMITTEE RECOMMENDS THAT A KEY POSITION BE ESTABLISHED IN THE OFFICE OF REHABILITATION TO COORDINATE THE REHABILITATION EFFORTS OF OUT-REACH PROGRAMS. THIS STAFF PERSON SHOULD REPORT DIRECTLY TO THE COMMISSIONER. VOCATIONAL REHABILITATION STAFF SHOULD BE ASSIGNED TO THESE PROGRAMS AND BE PROVIDED WITH SPECIAL TRAINING TO PREPARE THEM FOR THIS ASSIGNMENT.

FINANCING OF SERVICES FOR VOCATIONAL REHABILITATION

Provision and Payment of Services

In large part, vocational rehabilitation services in New York State are provided by voluntary agencies. The financial resources of these agencies vary considerably. The ability of these agencies to raise adequate capital funds, and funds for program improvement and expansion also varies. Facilities have been faced with major problems related to the rapidly increasing costs of operation, the financial competition to attract good professional staff, and other problems. A major source of income is in the form of payment for services rendered to clients sponsored by government agencies for vocational rehabilitation. It is important that there be a mutual understanding of the problems and the nature of this financial payment for services by the facility providing services, and by the government agency paying for it.

Vocational rehabilitation services are purchased by the Division of Vocational Rehabilitation and the Commission for the Blind and Visually Handicapped from various agencies on a fee basis. Fees may have only a limited relationship to the net cost to the agency for the services. The federal government and some state agencies make grants flexible through annual reviews which anticipate increased costs and differential costs in various communities. If the service agencies seek greater realism in the fee structure, they should adopt a fairly uniform accounting method which will detail the cost inputs, and they should make their financial records available for analysis and audit.

> THE COMMITTEE RECOMMENDS THAT THE STATE VOCATIONAL REHABILITATION AGENCIES DEVELOP A MORE REALISTIC FEE SCHEDULE FOR SERVICES PURCHASED WHICH MORE NEARLY REFLECTS THE ACTUAL COSTS OF PROVIDING THE SERVICES.

Community Financial Participation in Facility Operation

Community support is an essential ingredient of a successful vocational rehabilitation program. Support may be demonstrated in a number of ways, but it is generally translated in terms of financial support for capital construction or operation of the rehabilitation facility. Such community support will have many other advantages, including positive attitudes toward the disabled, employment opportunities, and willingness of community leadership to give time and effort to the center's program among others. We should, however, fully realize that in many communities competition among voluntary agencies for financial support has increased. Likewise, program costs in general have increased faster than the community is financially able to support most existing programs or develop new ones. Many Community Chests or United Funds are not giving financial assistance to agencies or programs until they have been in operation for two years. A government agency evaluating community participation should be aware of these factors and include them in its own consideration for the type of support which is given to programs.

Local Attitudes Toward Regional Programs

Vocational rehabilitation programs which serve geographic areas outside of their immediate communities can expect to encounter difficulty in obtaining local community financial support for those programs providing services to non-residents of the community except to the degree that the same program may also relate to a local service. Likewise, fund raising groups in communities located outside the geographic location of the facility may acknowledge services are being given to their residents, but because of local pressures for fund raising dollars, will tend not to allocate funds to these agencies, or at best, make only token allocations.

> THE COMMITTEE RECOMMENDS THAT A FORMULA BE DEVELOPED FOR PAYMENT OF SERVICES PURCHASED THAT FACTORS IN THE INABILITY OF OBTAINING LOCAL COMMUNITY SUPPORT FOR PROGRAMS SERVING POPULATIONS OUTSIDE THE COMMUNITY'S GEOGRAPHIC AREA.

Capital Funds

The costs of construction and equipment have shown a rapid increase and will probably continue to do so. Bonafide requests from community organizations to raise capital funds exceed the ability of the community organizations to raise capital funds even though the program itself may have good community acceptance. There are a number of federal programs which now make certain matching funds available through the state for this purpose. Federal programs now recognize capital depreciation in computing costs for services and this should assist centers in replacement costs for expansion in the future. Similar consideration should be given to payment for vocational rehabilitation services.

THE COMMITTEE RECOMMENDS THAT MATCHING FUNDS REQUIRED BY THE STATE SHOULD BE APPROPRIATED TO TAKE MAXIMUM ADVANTAGE OF FEDERAL ALLOCATIONS.

Contingency Funds

Today 20 percent of the total case service costs in the Division of Vocational Rehabilitation are spent in rehabilitation facilities. By 1970, 50 percent will be spent and 80 percent will be spent by 1973. This points out the need for consolidation of services and for developing multi-service facilities which serve all the handicapped.

> THE COMMITTEE RECOMMENDS THAT THE DIVISION OF VOCATIONAL REHABILITATION MAKE AVAILABLE CONTINGENCY FUNDS TO REHABILITATION CENTERS AND WORKSHOPS TO ENABLE THEM TO EXPAND EXISTING FACILITIES TO SERVE MORE DISABILITIES AND TO ALLOW THEM GREATER FLEXIBILITY IN GEARING FOR NEW VOCATIONAL OPPORTUNITIES AND CHANGING LABOR MARKETS.

Support During Training

In New York State, an agreement has been reached between the Division of Vocational Rehabilitation and the Department of Social Services that the first $25.00 given by the Division of Vocational Rehabilitation on training allowances will not be deducted from a client's welfare allowance. There are many welfare clients who cannot avail themselves of services through the Division of Vocational Rehabilitation program because they would be required to spend money and there are no other funds forthcoming for the client and his family. It is of utmost importance that support be given to those individuals who require rehabilitation services and who at the same time require funds to live on during the rehabilitation program.

> THE COMMITTEE RECOMMENDS THAT IN LIGHT OF TODAY'S COSTS, A REALISTIC CLIENT SUPPORT PROGRAM BE DEVELOPED WITH THE DEPARTMENT OF SOCIAL SERVICES FOR THE PERIOD WHEN CLIENTS ARE PARTICIPATING IN REHABILITATION PROGRAMS.

Workshop Support

The primary goal of a workshop is not to provide competition with industry, but to serve as a setting for rehabilitation. Workshops should have two functions: as terminal employment for those unable to enter competitive employment, and as competitive workshops. The terminal section could be 100 percent subsidized. The competitive section could be subsidized to the point that contracts with business and industry would be the means for rehabilitating people and not a goal to support the workshop. If we can supply grants to farmers to permit them to remove land from production and grants to business and industry, we can also increase our grants for rehabilitating people.

> THE COMMITTEE RECOMMENDS THAT SINCE LARGE SUMS OF MONEY ARE INVOLVED, A STUDY OF NEW WAYS TO SUPPORT WORKSHOPS SHOULD BE CONDUCTED BY THE DIVISION OF VOCATIONAL REHABILITATION.

In the broad concept of rehabilitation, gainful employment can be offered to all disability groups. The majority of clients within these groups who will be only marginally productive should be offered a program in which their gains will be in the area of social and emotional adjustment. After a prolonged period of vocational evaluation and personal adjustment training sponsored by the Division of Vocational Rehabilitation, it would be wasteful to let this group return home to regress. Experience shows that these people can continue to develop additional skills and to show growth in social development if they are in an environment which provides meaningful activity and interaction with others.

> THE COMMITTEE RECOMMENDS THAT SUPPLEMENTARY GRANTS BE PROVIDED FOR THE SUPPORT OF SEVERELY AND MULTIPLY DISABLED CLIENTS TO ENCOURAGE THEIR PARTICIPATION IN TERMINAL WORKSHOP PROGRAMS.

Grant Support

The financing of expanded programs related to rehabilitation cannot, with the present taxing structure, be expected to develop on local or county levels. It is beyond the scope of this Committee to design new relationships between state and federal grants structures, but it is considered essential for expanded programs. An essential component of any federal-state financing of local program services should be the feature of continuity. As presently, provided, federal-state financing seeds programs, but leaves to local communities the responsibility of not only continuing the programs, but also of expanding them. The expansion of programs or the introduction of new elements should, in principal, utilize the existing organizational structure and should not duplicate or disrupt established institutional patterns. Percentage grants, which anticipate expanded local financing have, in our opinion, passed their maximum utility. This is true whether such conditioned grants are made to public or private agencies. Reimbursement to facilities for services rendered is one method of offsetting support which facilities lose as grants expire.

The experience of industry has proven that "start-up" costs for a program greatly exceed the cost of sustaining such programs once they are operational. The same principle should be applied to the rehabilitation program and recognized in providing financial support. The same factors might be applied to new facilities which will need particularly strong assistance in their periods of initial development. It is generally recognized that larger facilities have qualified personnel which enable them to function more effectively and enable them more easily to expand and develop new programs. New programs that have not acquired this ability will need strong support if they are to be a success during the "start-up" period.

In considering the development of financial support for rehabilitation facilities, it should be realized that there are many factors to be considered from both the government and voluntary sector. Before formulas are set, government agencies should consult knowledgeable professionals from all the public and voluntary agencies which would be involved or affected. Possibly such a formula might be revised on an annual basis, and consultation, in that case, should be on some type of continuing basis.

> THE COMMITTEE RECOMMENDS THAT AN INTENSIVE STUDY BE MADE TO EVALUATE THE EFFECTIVENESS OF SUPPORT GRANTS AND THE USE OF OTHER FINANCIAL RESOURCES TO SUPPORT NEW AND EXPANDING PROGRAMS. THE STUDY SHOULD DETERMINE HOW THESE FINANCIAL RESOURCES CAN BEST BE UTILIZED AND SHOULD CONSIDER A POINT OF DIMINISHING RETURN FOR DOLLARS SPENT AS RELATED TO REHABILITATION SUCCESS.

Master Planning

Each agency operating in New York State which receives grant funds should have a master plan for its institution for at least a ten-year period with the provision that such a plan be updated every five years. The plan need not necessarily be in compliance with a State plan but should be reasonably related. Such a plan would give state agency officials useful information for planning and would also provide the boards of directors of facilities with defined agency goals, as well as providing "feedback" from state agencies to operative agencies. This should encourage cooperation between government and voluntary agencies but not used as a control measure to discourage community initiative.

SPECIAL AREAS OF CONCERN

Transportation

Transportation for persons needing vocational rehabilitation services has been continuously mentioned in Committee discussions as a major problem affecting delivery of services including, in certain instances, employment. There has been some indication that this problem has been partially resolved by various local programs. However, a large percentage of facilities indicate that transportation continues to be a problem for them.

In Region III there have been major improvements in the state highway system which have dramatically reduced the amount of time necessary to reach service locations. This is particularly true in and around the larger population centers. There has also been significant increase in highway transportation systems running north and south. For example, the Adirondack Northway, which runs from Albany to Montreal, has considerably reduced travel time in this sector of the state. Isolated groups living close to the major highway networks may now reach centers of larger population in a reasonable commuting time. This is especially true if we consider the major population centers and those which have some rehabilitation services such as Watertown, Plattsburgh, Syracuse, Utica, Schenectady, Albany, Troy, Poughkeepsie, and Binghamton. A large percentage of the population lives within an hour's travel of these communities.

Generally, in the area of community service, transportation systems are very limited. If the person to be served does not drive, or cannot arrange transportation by automobile, a barrier to his rehabilitation is created. It is not believed feasible to attempt to take most services to these isolated individuals because of the manpower problem and the high service cost of such a program. It would likewise be inefficient and expensive to establish many different types of rehabilitation programs in smaller communities. One alternative is to bring the client to the service and provide adequate housing for him while service is being rendered. In certain communities there may be adequate resources available for housing, or individual homes could be arranged for. In other communities it may be necessary to consider establishing residence housing in conjunction with rehabilitation facilities. Clients with special problems may need supervision by rehabilitation personnel during the early stages of their rehabilitation program and should not be placed in community housing.

One important facet of rehabilitation programs should be driver training. Every effort should be made, as a part of the rehabilitation program, to bring individuals to a level of being able to transport themselves, since subsequently it will be of major importance in many instances in securing competitive employment. High schools offer driving training.

> THE COMMITTEE RECOMMENDS THAT ARRANGEMENTS BE MADE FOR REHABILITATION PROGRAMS TO INCLUDE DRIVER TRAINING FOR THE DISABLED.

The need for developing a transportation system in the "North Country" is paramount to rendering services for those who need it most. Since Clinton County is predominantly a rural county with Plattsburgh as the focal point, a transportation system would make services available to the majority of those people in need of them. At this writing, the services available are reaching less than ten percent of the population. An alternative plan might be mobile clinics containing units such as speech, hearing and physical therapy, and diagnostic services which would travel into the rural areas to give services. The majority of the problems in the "North Country" stem from the lack of transportation. The existing facilities are adequate at the present time, but transportation must become a reality if we are to begin to serve the population in need. This becomes more apparent when considering the other counties surrounding Clinton which at the present time are using the Clinton County facilities. We cannot stress enough the importance of a transportation system to make services available. There also seems to be a problem in the transportation of the handicapped to doctor's offices, therapeutic and training centers and other places.

> THE COMMITTEE THEREFORE RECOMMENDS THAT THE POSSIBILITY OF MERGING TRANSPORTATION NEEDS WITH OTHER AGENCIES SUCH AS THE PUBLIC SCHOOLS BE EXPLORED TO SEE WHETHER THE FACILITIES AND EQUIPMENT AVAILABLE COULD BE UTILIZED FOR THE HANDICAPPED ON CERTAIN DAYS OR AT CERTAIN TIMES. THIS, OF COURSE, WOULD HAVE TO INCLUDE TRANSPORTATION BEYOND COUNTY BOUNDARIES AT TIMES, SINCE SPECIALIZED SERVICES TO THE HANDICAPPED ARE NOT AVAILABLE IN EACH COUNTY.

Service patterns tend to follow commuting flow and transportation can be a major factor for rehabilitation programming. The problem of transportation can be a complex one, ranging from the problem of transportation of persons residing in rural areas, to the problem of the urban citizen who does not drive and lives in an area where no bus transportation exists. In locating facilities, consideration should include transportation as a factor. In major communities, subsidized public transportation may need to be considered, not only as related to rehabilitation but as to other population groups who may not have private transportation. Also, grant funds or support of state agencies for transportation services in rehabilitation settings might be considered. Another factor in transportation programs to be considered would be use of volunteers from other community organizations to provide transportation services. Successful rehabilitation programs in certain instances may involve relocation of the disabled person because of the transportation factor, and should be considered.

THE COMMITTEE RECOMMENDS THAT EVERY EFFORT BE MADE AND EVERY RESOURCE EXPLORED AND UTILIZED TO SOLVE THE PROBLEMS OF TRANSPORTATION TO SERVICES.

Architectural Barriers

The efforts which have been made by the Division of Vocational Rehabilitation to reduce architectural barriers are producing results. Many public buildings are now being constructed which permit entry and use by the disabled due to increased concern in this area. Elimination of architectural barriers should be part of a public information program, recommended earlier.

THE COMMITTEE RECOMMENDS THAT THE DIVISION OF VOCATIONAL REHABILITATION CONTINUE ITS ROLE IN THE STATE IN REDUCING ARCHITECTURAL BARRIERS.

Employment of the Handicapped

When the public information program is initiated, as recommended earlier, it should develop close cooperation with the Governor's Committee on Employment of the Handicapped. Material can be procured from that Office which would be useful for the vocational rehabilitation public information program. A good program of placement and follow-up services for the disabled should be developed between the Division of Vocational Rehabilitation, and rehabilitation facilities, and placement specialists in the New York State Employment Service. Placement specialists should attend appropriate team conferences in rehabilitation facilities which relate to clients they are being asked to place.

THE COMMITTEE RECOMMENDS THAT THE RELATIONSHIP BETWEEN THE DIVISION OF VOCATIONAL REHABILITATION AND THE NEW YORK STATE EMPLOYMENT OFFICE BE STRENGTHENED.

Cooperation with Private Industry

Both government and voluntary agencies should make continuous efforts to secure full understanding and cooperation from private industry for vocational rehabilitation programs. Rehabilitation facilities in particular may improve relations by the involvement of key community individuals in their programs. Public information programs can also substantially contribute to this understanding. It should be realized that in obtaining cooperation from private industry, cooperation and understanding is needed from union leaders and private industry employees.

THE COMMITTEE RECOMMENDS THAT STAFF MEMBERS BE ASSIGNED ON AN AREA BASIS TO WORK WITH PERSONNEL DIRECTORS OF BUSINESS FIRMS TO IMPROVE RELATIONS AND ESTABLISH EMPLOYMENT OPPORTUNITIES.

Cooperation With Civil Service

New York State government is an exceptionally large employer and is in a position to make available a substantial number of jobs to the disabled who are qualified. It is therefore important that the State rehabilitation agencies develop a close working relationship with the Civil Service Commission.

THE COMMITTEE RECOMMENDS UTILIZATION OF A QUALIFIED COMMITTEE TO ASSIST IN DEVELOPING FLEXIBLE STANDARDS FOR THE HIRING OF THE DISABLED THROUGH CIVIL SERVICE.

Cooperation With Employers

Business and industry have displayed an interest in providing on-the-job skill training. They should be encouraged, through government subsidy if necessary. In New York State, non-terminal workshops could be programmed to meet the manpower needs of business and industry. If the business requiring increased manpower is located some distance from the home territory, a plan of resettlement loans should be set up enabling the client to move to the work location.

THE COMMITTEE RECOMMENDS A LONG-RANGE INTENSIVE SURVEY AT THE NATIONAL LEVEL BY THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE IN COOPERATION WITH BUSINESS AND LABOR TO PROJECT JOB NEEDS FOR THE NEXT 10 TO 20 YEARS WHICH WOULD INCLUDE IDENTIFYING NEW INDUSTRIES AND BUSINESSES REQUIRING NEW SKILLS. AN ADVISORY COMMITTEE OF THE COUNTRY'S LEADERSHIP SHOULD WORK WITH THIS PROJECT.

District V Report on the Aging

The 1960 Census of persons 65 and over for three counties in District V showed Clinton County with a population of 5,163, Essex County with 4,062, and Franklin County with 4,973. The following sources revealed that there is no breakdown available by disability within this age group for District V: Clinton County Health Department, Clinton County Department of Social Service, Tri-County Council on the Aging, U.S. Department of Health Education and Welfare, Social Security Administration, and the Division of Vocational Rehabilitation District Office in Malone. A 1965 reference from the United States Department of Health, Education and Welfare, Social Security Administration Office of Research and Statistics revealed a breakdown only by state.

Case Study

> To illustrate what appears to be a serious lack of facilities and manpower for this age group, the following case study has been prepared from actual case records.

Mrs. Jones, widowed, age 69 resides in the Plattsburgh Housing for the Elderly at Cornelia Street. Her only income is from Social Security. Mrs. Jones moved into her apartment in April 1967. She has no means of transportation, owns only a few odd pieces of furniture. In October 1967, a neighbor brought a letter from Mrs. Jones concerning her medicare benefits to the newly established Office for the Aging. The program director went to call. She found the following conditions:

- Mrs. Jones had not been outside her apartment since she moved in the previous April, a period of six months.
- After her husband's death Mrs. Jones did not know where to find help in regard to her Medicare eligibility.
- She received a call from "some office" telling her she had not returned the forms that were past due.
- She was afraid of other people in the apartment building and said that she could hear them talking about her through the walls. It appeared that she was totally lacking in any social contacts.
- She had no children of her own and the children from her husband's first marriage would not visit her or help her in any way.
- There was evidence that she was not eating properly and she had few articles of clothing that were warm and clean.

The program director concluded that although Mrs. Jones had an adequate place in which to live, she needed help with financial problems, recreation, social contacts and meal planning. She also felt that Mrs. Jones was emotionally disturbed and needed professional help.

There is no one agency to act as an information and referral service where the elderly can call for assistance in finding services. Although Mrs. Jones could have received counseling from a social worker her needs were totally neglected. She finally sought help from a neighbor who brought the problem to the attention of the Tri-County Office for the Aging. The Office set up an appointment with the Social Security Office and the program director took Mrs. Jones there in her car and helped her to explain her problem. Her immediate problem was taken care of - her other problems continue to exist.

Services available in this community:

Mental Health Clinic - fees charged according to ability to pay.
Opportunity Workshop - a facility where mentally retarded adults may be taught a skill.
Alcohol Information Center - furnished information on help for the alcoholic.

Services Lacking:

No central office for information and referral, or counseling of the aging.
No organized volunteer visitation program.
No clinics for the health problems of the aged.
Not enough nursing homes to take care of the needs of the area.
No facility for blind, deaf, or speech handicapped.
No neurological facility.

Programs and Facilities Being Planned:

- High rise apartments for the aging. This will include facilities for recreation, work projects, space for clinics, and kitchen and dining area. There will be a need to recruit volunteers to assist in programs using this new facility.
- Home health program. The Clinton County Health Department has agreed to train homemakers in the Homemaker Service Agency as Home Health Aides. This will provide the service to the elderly which they are eligible to receive under Medicare.
- The Tri-County Council for the aging was organized in 1967 and it is attempting to provide self-help units for the aging. Some groundwork has been done in establishing a few Senior Citizens centers, especially in Franklin County. A ten percent discount plan is being implemented to assist the elderly in stretching their modest incomes. The council has not yet accomplished many of its goals as it has been functioning only a short period of time.
- The new medical facility now being built will provide some rehabilitation services, but these have not been identified as yet. Equipment has been purchased for a neurological unit but it is not functioning at the present time.

It would appear that in the Tri-County area with a total of 14,138 citizens 65 years of age and over, there are many unmet needs and very few services available locally, making it necessary for residents to travel out of the county to find needed services.

Should facilities be forthcoming, the community would be faced with a serious manpower shortage. The area is economically too poor to attract and hold professional people and those who do come soon move on to better paying jobs with more opportunity. It is the general feeling that requirements for professional personnel should be relaxed to assist economically disadvantaged communities in hiring qualified people who may have education and experience but who may not have the required degrees. Salaries for professional staff in this area should be higher to attract and hold competent people.

LEGISLATION

Amendments to the Vocational Rehabilitation Act recently enacted are having broad effects on rehabilitation programs. A revision of the fiscal relationship between the Federal and State governments provides a much greater flow of federal money into the program. New programs have been established and older ones strengthened. After a thorough study of current legislation, the Committee felt that by providing proper and sufficient funds to rehabilitation agencies existing laws could be implemented to support rehabilitation goals. The Executive and Legislative branches of Federal and State governments must be alerted to the great and pressing need for appropriations to pursue the objectives set forth in other sections of this report.

> THE COMMITTEE RECOMMENDS THAT EITHER BY EXECUTIVE OR LEGISLATIVE ACTION THE DIVISION OF VOCATIONAL REHABILITATION AND COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED SHOULD BE PLACED IN THE EXECUTIVE OFFICE AS THE "OFFICE OF REHABILITATION" TO EFFECTIVELY CO-ORDINATE STATE AND LOCAL SERVICES AS DESCRIBED ELSEWHERE IN THIS REPORT.

> THE COMMITTEE RECOMMENDS THAT THE GOVERNOR APPOINT A JOINT LEGISLATIVE REHABILITATION COMMITTEE WHICH WILL FOCUS ITS ATTENTION ON REHABILITATION NEEDS, PROGRAMS, AND FUNDING.

> THE COMMITTEE RECOMMENDS THAT THE PROPOSED LEGISLATIVE COMMITTEE SEEK INCREASED STATE FUNDS FOR THIS PROGRAM. AT THE PRESENT TIME THERE IS NO REASON TO EXPECT THAT THE RATIO OF FEDERAL DOLLARS TO STATE DOLLARS WILL EXPAND MUCH MORE.

> THE COMMITTEE RECOMMENDS A STUDY OF THE LAWS WHICH ACT AS A DETERRENT TO EMPLOYERS WHO ARE WILLING TO EMPLOY THE HANDICAPPED.

REFERENCES

Brandt, Robert L., "Rehabilitation of the Chronically Short of Breath," Position Paper Submitted to the Region III Planning District of the Office of Statewide Planning for Vocational Rehabilitation, 1968.

______,"Facts About Older Americans," Brochure published by the United States Department of Health, Education and Welfare, No. 410, May, 1966.

LaVerne, Senator Thomas, The Manpower Paradox, Report of the New York State Senate Committee on Manpower Needs, 1968.

March, Michael S., "The Neighborhood Center Concept," Draft. United States Bureau of the Budget, August, 1967.

McNutt, Thomas H. "Information Storage, Retrieval and Dissemination Centers," Paper presented at the Region IV Quarterly Meeting of Statewide Planning Directors, September, 1967.

______,"The Medical Assistance Program," Rehabilitation Interagency Focus, Vol. 11, No. 4.

______,"More Aides for the Elderly Urged," editorial in the Syracuse Post-Standard, May 9, 1968, p. 22.

______,The Physically Disabled and Their Environment, Report of the Proceedings: Conferences of the International Society for the Rehabilitation of the Disabled, Stockholm, October, 1961.

______,Principles of Health Planning," Policy Statement of the American Public Health Association, Miami, October, 1967.

______,The Public Information Act," Rehabilitation Interagency Focus, No. 4, December, 1967.

______,"Recommendations of the Task Force on the Psycho-Socially Disabled," Final Report of the Comprehensive Statewide Planning Project for Vocational Rehabilitation Services: New Jersey, New Jersey Rehabilitation Commission, August, 1968.

______,"Regional Support of Education in the Albany Capital Area," Paper published by the Bureau of Education and Finance Research of the New York State Department of Education, Albany, July, 1968.

______,Rehabilitation and Health: A Report to Unions and Health and Welfare Agencies, Publication of the National Institute on Rehabilitation and Health Services, Vol VI: No 5, May, 1968, and Vol. VI: No. 8, August,1968.

______,Report of the National Citizens Advisory Committee on Vocational Rehabilitation, United States Government Printing Office, Washington, D.C., June, 1968.

Schottland, Charles I, "The Future of State Planning for Public Welfare Programs," Planning Responsibilities of State Departments of Public Welfare, Proceedings of the Conference, Brandeis University, Waltham, Massachusetts, November, 1966.

______,"Summary Statement," Los Angeles Management Council, Los Angeles, California, 1968.

______,This is One Way, Final report of a demonstration project on the team approach in the intake process: Grant No. 147, Arkansas Rehabilitation Services, October, 1961, pp. 4-12.

______,Vital Issues and Recommendations From the 1965 National Institutes for Rehabilitation Research, Martin Dishart, Project Director, National Rehabilitation Association, Washington, D.C., October,1965.

______,"The Bright Promise of Neighborhood Health Centers," The Reporter, March 21, 1968,

Rief, Robert and Frank Riesman," The Indigenous Nonprofessional," 1967 Community Mental Health Journal by Behavioral Publications, Inc.

News release from HEW - "Federal Vocational Rehabilitation Services and Welfare Program Joined Under Single Agency Headed by Mrs. Switzer."

Excerpts from the Mental Hygiene Plan

APPENDICES

APPENDIX A

Table I

TOTAL POPULATION AND PRELIMINARY ESTIMATES OF NUMBER OF PERSONS* UNABLE TO CARRY ON MAJOR ACTIVITY BY SELECTED AGE GROUPS FOR REGION III OF NEW YORK STATE 1965

AGE	TOTAL POPULATION	Estimated Number of Persons Unable to Carry on Major Activity			
		TOTAL	DUE TO CHRONIC CONDITIONS**	DUE TO MENTAL AND NERVOUS CONDITIONS	DUE TO MENTAL RETARDATION
All Ages	3,564,042	145,459	81,698	9,049	54,712
Under 17 years	1,121,765	27,587	1,683	673	25,231
17-44 years	1,266,295	25,572	5,696	2,152	17,724
45-64 years	802,227	30,797	19,169	3,609	8,021
65 + years	373,755	61,503	55,150	2,615	3,736

* Does not include institutional population

** Mental and Nervous Conditions and Mental Retardation were not included in this category but estimated separately

Table II

PROJECTED POPULATION AND PRELIMINARY ESTIMATES OF NUMBER OF PERSONS* UNABLE TO CARRY ON MAJOR ACTIVITY BY SELECTED AGE GROUPS FOR REGION III OF NEW YORK STATE 1975

AGE	TOTAL POPULATION	Estimated Number of Persons Unable to Carry on Major Activity			
		TOTAL	DUE TO CHRONIC CONDITIONS**	DUE TO MENTAL AND NERVOUS CONDITIONS	DUE TO MENTAL RETARDATION
All Ages	4,057,935	168,700	96,551	10,456	61,693
Under 17 years	1,205,753	29,678	1,810	724	27,144
17-44 years	1,510,358	30,498	6,794	2,567	21,137
45-64 years	889,816	34,155	21,258	4,003	8,894
65 + years	452,008	74,369	66,689	3,162	4,518

* Does not include institutional population

** Mental and Nervous Conditions and Mental Retardation were not included in this category but estimated separately

APPENDIX B

DISTRICT RECOMMENDATIONS

The report of Region III has been developed by integrating the reports of the district committees. An attempt has been made to include the concepts and recommendations which were developed in each district. However, some recommendations have been made by only one district and may be a concern which is unique to that district. In other cases, the district recommendation may be more refined than the regional report suggests. For these reasons, the Committee includes the following district recommendations.

Program Recommendations

1. That specific and meaningful programs be established for the blind and deaf through the respective Boards of Cooperative Educational Units in each county. There are no specific programs for the blind and deaf groups in the seven-county area covered by the District II Committee.

2. That existing workshop facilities be expanded to include special programs and special staffing to meet the needs of the blind and deaf to help them complete their education.

3. That job training programs be established in those institutions where they are presently nonexistent.

4. That the hard core and the culturally deprived be provided a more important place in casework plans for handicapped persons; that definite steps be taken to improve the skills and techniques which will be needed in attempting to overcome the attitudinal and emotional problems in the handicapped.

5. That volunteer groups be organized on a community basis since there is a great need for developing outreach programs for rural counties to reach the homebound, the unmotivated and those unaware of services which are available. Every community has volunteer groups which could and frequently would undertake worthwhile projects - such groups as P.T.A.'s, Girl and Boy Scouts, Volunteer Firemen, service groups such as the Lions and Kiwanas Clubs. Most state agencies ignore such groups, preferring to use professional staff to provide services. Consequently, these local groups are underutilized when they could be extremely effective in helping to serve their communities.

Manpower Recommendations

1. The job of community specialist should be established. This person should live in the county and could organize the leadership of these groups to aid in identifying persons they and their groups know who need service. By establishing a "hot line" to the counselor's office, referrals could be made by phone to an intake person. Where multiservice centers are established, the client could be brought in for evaluation and service.

2. That brochures be developed for personnel recruitment and training for distribution to referral agencies, describing Division of Vocational Rehabilitation's services, eligibility, criteria, etc.

3. That a training program be developed which will circulate throughout the state, providing special information concerning rehabilitation to general practioners and the general public.

4. That arrangements be made for a series of lectures to be given at various universities and training centers which are preparing manpower in the health fields.

5. That curriculum materials be developed in the health education area related to rehabilitation.

6. That the in-service training programs be expanded to include internships which would permit paid learning as well as attendance at school.

7. That the Division of Vocational Rehabilitation develop the "ombudsman" concept, and that a position for this individual be established. His job would be to go to all hospitals and agencies, attend conferences, etc. He would followup with individual persons through the entire spectrum of services and treatment. He would be in a position to see that both the state operations and local, private agencies are working for the full benefit of the individuals. He would be responsible for every individual in his county who needs his services. When the client leaves hospitals, he would make all the followup contacts until the client is rehabilitated. He would act as a coordinator in the community, starting with people who are already in a hospital or rehabilitation center.

8. That agreements be developed with unions to enable a handicapped person who performs well in his work not to be forced by union agreements into a higher position in which he cannot perform satisfactorily.

9. That school physical examination reports be made mandatory - from the family physician or public resources for early identification of neurological and emotionally handicapped children.

10. That a method be developed for seeing to it that people reach the source of help that they need. Referrals should not be a casual instruction, but an active process of accompanying and aid to the individual, first to a diagnostic center and then to other services as needed. There is a need for a "shepherding" concept for clients. Currently, agencies tell people where to go and then leave them to their own resources.

11. That the state mandate, as a condition for receiving public funds, that all local organizations receiving such funds should participate actively in a yearly or twice yearly training meeting on referrals, intercoordination and cooperation. There should also be continuous seminars held among the rehabilitation agencies using their professional experts to provide joint seminars in order to acquaint one another of each other's functions, roles, new programs, inter-agency research programs, and to have the benefit of one another's expertise. The Division of Vocational Rehabilitation should sponsor these programs.

12. That the Office for Planning Coordination should be expanded to include social and health areas to develop an overall state plan by bringing together the various departmental state plans, which are currently being developed separately.
    a. Social and health planning should be equal and coordinate with physical planning.
    b. Research and planning should not be done by the people who carry out operations.

13. That persons with post-high school courses, workshop seminars and other pertinent experiences who can fill the manpower need by serving as counselor's aides to full professional workers be accepted as paraprofessionals. Concurrent with this concept, the Committee recommends that the undergraduate schools in the State University system, including in particular the two-year institutions, should be involved in analyzing this need and should help to develop appropriate curricula to meet it. Such training is currently nonexistent in many areas of the state and too few persons are being trained in the service fields due to lack of such technical training.

14. That staff be assigned to work with student councils and guidance officers to develop manpower programs in the colleges and universities in New York State. Student volunteers can be used to serve in such capacity as "transportation aides" in taking people to services or teaching them transportation routes so that they can reach the services themselves. They can also serve as a babysitting service so parents can receive treatment.

15. That future planning should provide for attracting more persons into rehabilitation counseling for the blind. Furthermore, provision should be made, as in all phases of rehabilitation, for persons to be able to enter the field of rehabilitation counseling as case aides, or similar titles, with less than the full qualifications required for certification as a rehabilitation counselor.

16. That an all-out sustained effort be made to encourage individuals who are trained to do technical work, as well as professionals, to re-enter the professional ranks at whatever level their competency permits, and to encourage them to update or upgrade their achievement level while being employed.

17. That the rehabilitation field be made attractive to workers in order to recruit and hold them. This involves offering proper training at relatively local centers and at relatively low cost, and increase in salary scales, more status and recognition, and the creation of new technical or semi-professional titles and positions.

18. That continual evaluation of programs become an integral part of Division of Vocational Rehabilitation.

19. That the Division of Vocational Rehabilitation should work with community colleges to provide courses needed for the requirements of the position of vocational rehabilitation counselor aide and to develop seminars for high school guidance counselors, for purposes of orientation to vocational rehabilitation for students who may be stimulated to become interested in the rehabilitation field.

Work experience in the vocational field should be made available for the three-year college student as a method of recruitment.

The Division of Vocational Rehabilitation and the Commission for the Blind and Visually Handicapped should provide funds for the establishment of "assistant" or Vocational Rehabilitation Counselor Aide.

Paraprofessional staff should be recruited, trained and used for follow-through in state institutions when there is an absence of professional Division of Vocational Rehabilitation and/or appropriate institutional staff. The institutions would include the mental hospitals, state schools for the mentally retarded, adult correction and training schools and youth rehabilitation centers. It should be the responsibility of the Division of Vocational Rehabilitation and the Commission for the Blind and Visually Handicapped to develop for the handicapped in these institutions as well as for those on parole, comprehensive programs including: diagnostic evaluation, pre-vocational training programs, diversified work training programs, on-the-job training units while a number of these individuals are still in the care of the state institutional facility.

Transportation Recommendations

1. That a position of "Transportation Specialist" be developed to work with clients and show them how to get to services, teach them the transportation routes and help to motivate them to use their own resources.

2. That the state make funds available for costs in all appropriate instances such as:
   for local motor corps with specialized, trained volunteers;
   to develop with private ambulance services agreements whereby each trip for the rehabilitation agency is paid for by the agency;
   development of agreements with local school districts for sharing buses; and where agreements are reached with local bus companies which might include adding to their usual route in order to serve more people.

Finance Recommendations

1. That the Division of Vocational Rehabilitation and the Commission for the Blind and Visually Handicapped have a large contingency fund available for rehabilitation centers that might enable such centers to expand quickly in specific directions or to offer newly needed training almost immediately, thus giving the retrained handicapped worker a distinct advantage in the labor market. Long delays occur before a private rehabilitation agency has the resources necessary to prepare clients for new vocational opportunities, changing labor markets, and the new skills and techniques that are now called for. Otherwise, rehabilitation centers will find themselves training their clients for obsolete skills.

2. That grants from the federal and state governments be expanded to help more individuals desiring entrance and/or advanced training in rehabilitation work. It is unfortunately true that those "who have, get." In the context in which we are speaking it becomes quite apparent that the number of people in the area who have expertise in acquiring funds, facilities and other appurtenances bears direct relationship to such acquisition. Simply stated, there are few people in sparsely settled areas who have the necessary knowledge that will enable them to even apply for state aid or organize themselves effectively to deal with local problems. It is therefore apparent that one of the needs in an area such as District III is the provision of knowledgeable individuals to serve the outlying regions in identifying needs and identifying sources of help in meeting these needs.

3. That specific financial roles for the public and voluntary sectors be defined by a joint committee of knowledgeable professionals from within the Division of Vocational Rehabilitation and the Commission for the Blind and Visually Handicapped and selected voluntary agencies.

APPENDIX C

POSITION PAPERS

Various individuals and agencies involved in vocational rehabilitation were invited to submit comments and recommendations to the Region III planning group. Much of the material received was incorporated into the main body of the regional report. Specific recommendations and comments have been abstracted from the position papers and are presented below. The recommendations presented here are listed below the agency or other source which made them.

Albany Association for the Blind

- Expansion of professional and technical service to the blind such as itinerant teachers, social workers.
- Stronger legislation regarding compulsory reporting of blindness.
- Increased job opportunities.
- Central registry where all types of serious handicaps are reported and followed up by case study by a coordinator-counselor who knows rehabilitation services and who could make referrals.

Tri-County Respiratory Health Association

- State and local health departments must work with hospitals, clinics or other agencies to see that a cooperative program meets the demands of the area.
- Need for massive screening program for "chronic lungers" as a preventive measure. This disability is projected to be the number one disabler (equal to or exceeding heart disorders) of all times.

Neighborhood Youth Corps

- BOCES or Area Vocational schools need to set up special classes in reading, writing, arithmetic in 7th and 8th grade to prevent drop-outs.
- Need for adult education courses and high school equivalency courses in rural areas. Also need for counseling services.
- Need for close liaison on policies, procedures, and familiarization of State Department Agencies.

An Individual

- Develop seminars where businessmen can be informed about handicapped people.
- Develop more literature concerning handicapped people and the work they can do.
- Establish an employment agency especially for the handicapped which is easy to reach.

United Community Chest and Council of Onondaga County

- Need for formal education programs with the objective of communication of rehabilitation principles, concepts, functions, and services developed to reach all levels of the total community. Use of educational media (films, radio, and T.V. materials). Individualized programs assigned to reach employers, inner city, rural areas, etc.
- Creation of mechanics and procedures for the on-going identification of individuals in need of rehabilitation services should include concept of "reaching out" to people.
- Review and development of a formalized process for the following: referral, screening, communication of information, identification of needs, recording of services provided, rehabilitation planning, follow-up. Need more rapid and efficient delivery of services.
- A single agency should assume consideration of the individual's total needs.
- Need for public, private, and local identification and acceptance of appropriate standards of operations and services with periodic review.
- Dramatic expansion of training facilities for all types of professional and paraprofessional personnel. Application of the concept of utilizing aides, volunteers.
- Large-scale financial support programs must be developed on a continuing basis.
- Need for partnership of endeavor, both public and voluntary from local communities through county, state and federal government levels.
- Provision of special transportation services with some type of subsidy.
- Need for adequate long-term housing, free of architectural barriers and easily accessible to community resources. Also a need for housing in a supervised, protective residential setting for individuals who cannot maintain themselves in the community at large.
- There should be expansion of recreational and vocational programs to integrate the disabled persons into community life.

- Follow-up procedures and methods should be developed with major attention given to those persons identified as "unsuccessfully rehabilitated, unmotivated, marginal, or inadequate".

Occupations, Inc.

- Provision of a grant for support of severely and multiply disabled clients in terminal workshops.
- Allocation of additional funds to the Division of Vocational Rehabilitation to increase their staff of interviewers and counselors. Funds provided to hire psychologists and physicians as staff members.
- The system of matching funds on grants to workshops should be adjusted to meet changing and increasing needs in the community, and a decrease in financial support from the community.
- Make funds available to establish half-way houses as part of the Rehabilitation Facilities Program. This should include funds to purchase buildings and for staffing.

Broome County Committee on Alcoholism

- Elimination of the word "vocational" in Regional Committee title to read: "Statewide Committee on the Implementation of Rehabilitation Services".
- Encourage more effective cooperation between Vocational Rehabilitation and the local, state and national councils on alcoholism.
- Promote knowledge and understanding among professional workers concerning alcoholism rehabilitation.

An Individual

- Recommend that New York State offer vocational training and placement services on two levels: high school education and rehabilitation of the hard core unemployed.
- Implementation by New York State of a system of regional training centers for vocational skills similar in structure and administration to the community colleges and offering courses in carpentry, auto mechanics, cosmetology, graphics, agricultural mechanization, drafting, etc.
- Investigation of jointly financed private industry, government training and rehabilitation centers to bridge the job-transportation gap bringing skilled workers to where the jobs are available.
- Development of low cost dormitory units close to training centers.

Two Individuals

- Recommend that the criteria for "success" for mental patients be measured by the degree to which the patient's stay at a rehabilitation agency has contributed to the total well-being of the client and not whether he was placed in a job.
- Changes in the rehabilitation goals within each agency to provide job placement in addition to the vocational skills. Provide the services and milieu permitting formerly hospitalized patients to maximize their interpersonal skills, to feel useful, and a part of the working community.

An Individual

- Location of a full time counselor from the Division of Vocational Rehabilitation to serve as a resource and to coordinate all the services of the Division of Vocational Rehabilitation in the Dutchess County Mental Health Center.

Samaritan Hospital

- Need for home health aides, perhaps utilizing retired but capable senior citizens for recuperative programs in homes. Training programs through the County Public Health Service could certify them to be paid by Medicare or Medicaid.

An Individual

- Extend the rehabilitation program to people of all ages to include the senior handicapped citizens.

Glens Falls Association of the Blind, Inc.

- Location of Rehabilitation Centers in upper New York State nearer the residence and employment areas of the clients in training programs.

- Manpower development of counselors whose responsibility is to contact industry and obtain placement for rehabilitated clients.

Montgomery County Department of Social Service

- Provision of more personnel as field workers in local agencies for personal contacts, and to evaluate services for public and private individuals.

Rehabilitation Services, Inc.

- Need for adequate professional personnel, especially physical and occupational therapists.

An Individual

- Need for government agencies to assist training institutions in developing programs or courses for undergraduate education in rehabilitation.

New York State Department of Health, District Office

- Need for a sheltered workshop, residence type institution in the Johnstown area where disabled patients under supervision can work together in a productive way on either an in-patient or out-patient basis. It would also provide permanent residence for the younger age group and patients with a chronic disability.

Capital District Chapter, National Multiple Sclerosis Society

- Provide low cost rehabilitation and counseling, readily available for the family unit.

Wassaic State School, An Individual

- Recommend habilitation thereby reducing need for rehabilitation.
- Implementation of the law that already mandates classes for the mentally retarded on the secondary level.
- Make it possible for trainees to earn money without jeopardizing the welfare status of their parents.
- Recommend more coordination between agencies.
- Recommend more prompt reimbursement to workshops.

St. Peter's Hospital

- There is a need for apartments equipped for handicapped people.
- There is a need for special equipment such as braces for people before hospital discharge.
- There is a need for rehabilitation for useful living beside the vocational aspect of rehabilitation.
- There is a need for more homemaker service in the area, with a financial program to cover the patient receiving the service.

New York State Division American Cancer Society

- Coordination of services, legislation, manpower.

REPORT

of

REGIONAL ADVISORY COMMITTEE

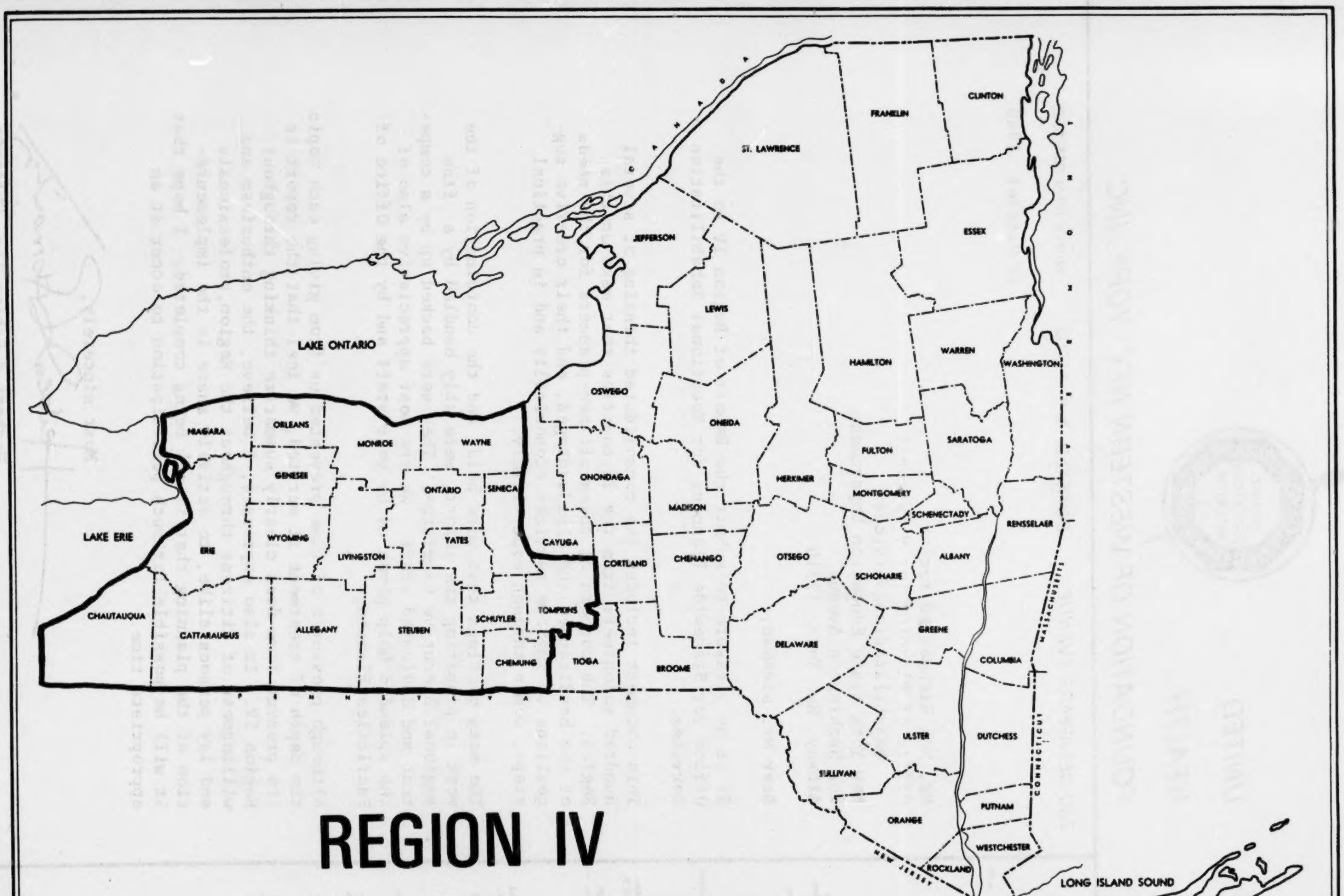
REGION IV

Allegany
Cattaraugus
Chautauqua
Chemung
Erie
Genesee
Livingston
Monroe
Niagara
Ontario
Orleans
Schuyler
Seneca
Steuben
Tompkins
Wayne
Wyoming
Yates

University of the State of New York
State Education Department
Office of Statewide Planning for Vocational Rehabilitation Services

October 1968

REGION IV


LAKE ONTARIO
LAKE ERIE
ONTARIO
PENNSYLVANIA
VERMONT
MASSACHUSETTS
CONNECTICUT
NEW JERSEY
LONG ISLAND SOUND
ATLANTIC OCEAN
CLINTON
FRANKLIN
ST. LAWRENCE
ESSEX
JEFFERSON
LEWIS
WARREN
WASHINGTON
HAMILTON
OSWEGO
ONEIDA
SARATOGA
FULTON
NIAGARA
ORLEANS
MONROE
WAYNE
ONONDAGA
HERKIMER
MONTGOMERY
SCHENECTADY
RENSSELAER
GENESEE
ONTARIO
SENECA
MADISON
ALBANY
WYOMING
YATES
CAYUGA
ERIE
LIVINGSTON
CORTLAND
CHENANGO
OTSEGO
SCHOHARIE
CHAUTAUQUA
CATTARAUGUS
ALLEGANY
STEUBEN
SCHUYLER
TOMPKINS
GREENE
DELAWARE
COLUMBIA
CHEMUNG
TIOGA
BROOME
ULSTER
DUTCHESS
SULLIVAN
ORANGE
PUTNAM
WESTCHESTER
ROCKLAND
BRONX
NEW YORK
QUEENS
KINGS
RICHMOND
NASSAU
SUFFOLK

UNITED

HEALTH

FOUNDATION OF WESTERN NEW YORK, INC.

SERVICE
EDUCATION
RESEARCH

UNITED HEALTH FOUNDATION OF WNY

220 DELAWARE AVENUE *BUFFALO, N.Y. 14202* *PHONE (716) 856-4065*

MEMBER AGENCIES

- Association for Children with Learning Disabilities of Western New York
- Buffalo Area Council on Alcoholism, Inc.
- Buffalo Eye Bank and Research Society, Inc.
- Buffalo Hearing and Speech Center, Inc.
- Cerebral Palsy Association of Western New York, Inc.
- Diabetes Detection Services of Erie County
- Epilepsy Association of Western New York
- Lay Society of the Buffalo Diabetes Association
- Mental Health Association of Erie County, Inc.
- Multiple Sclerosis Association of Western New York, U.F.
- New York State Association for Retarded Children, Inc. — Erie County Chapter
- Niagara Frontier Chapter Human Growth, Inc.
- Niagara Frontier Vocational Rehabilitation Center, Inc.
- Psychiatric Clinic, Inc., The
- Psychiatric Clinic, Jewish Family Service of Erie County
- Visiting Nursing Association of Buffalo, The
- Western New York Chapter, Arthritis and Rheumatism Foundation
- Western New York Chapter, National Hemophilia Foundation
- Western New York Chapter of the National Kidney Foundation, Inc.
- Western New York Sister Elizabeth Kenny Foundation, Inc.

18 October 1968

Mr. Sol Richman, Director
Office of Planning for Vocational
Rehabilitation Services
New York State Education Department
162 Washington Avenue
Albany, New York 12210

Dear Mr. Richman:

It is my pleasure to submit the Report of Region IV to the Office for Statewide Planning for Vocational Rehabilitation Services.

This document includes the consolidated thinking of several hundred volunteers from the 18 counties that make up this Region. The concern of these citizen-planners for the needs of the handicapped and disadvantaged, and their creative suggestions to improve services economically and in practical steps, comes through most vividly.

The many meetings that were held, and the coordination of the work in preparing the report, were ably handled by a fine regional Executive Committee. They were backed up by a competent and dedicated staff. We are most appreciative also of the splendid help given us by your staff and by the Office of Facilities Planning.

Although pressures of time prevented us from giving each topic the depth of treatment it merited, we feel that the report in its present form does clearly summarize thinking throughout Region IV. It also expresses, I believe, the enthusiasm and willingness of citizens throughout the Region, professionals and lay persons alike, to actively share in the implementation of the planning that is now being completed. I hope that it will be possible for such participation to occur at an appropriate time.

Most sincerely,

Herbert Rabinowitz

Herbert s.Rabinowitz, Chairman
Advisory Committee - Region IV

TABLE OF CONTENTS

Regional Map 309

Regional Committee Members and Consultants 313

Foreword 320

Profile of the Region 322

Estimates of Disability 326

Recommendations 328

Disability Recommendations 330

- Blind 330
- Deaf 331
- Mentally Ill 332
- Mentally Retarded 333
- Socially and Culturally Disadvantaged 333
- Special Problems 334

Programs 336

Interagency Coordination of Service Programs 344

Administrative Aspects 346

Coordination With Other State Planning 350

Special Planning Topics 352

References 354

REGION IV

Herbert S. Rabinowitz Chairman	Earl W. Fahy Vice-Chairman

EXECUTIVE COMMITTEE

District 6

Willard Gold, M.D.	Chairman
Joseph Mineo	Vice-Chairman

District 7

George Lawn	Chairman
Dorothea Aitken	Vice-Chairman

District 7A

Arnold Jerome	Chairman
Franziska Racker, M.D.	Vice-Chairman

District 8

Thomas R. Sonne	Chairman
Angelo J. Cardarelli	Vice-Chairman

Division of Vocational Rehabilitation

Edward J. Bryant
John Evanko

Commission for the Blind and Visually Handicapped

Elizabeth J. Smith

Regional Rehabilitation Services Coordinator

Angelo J. Cardarelli
Roy H. Fabry

REGIONAL ADVISORY COMMITTEE

Dorothea Aitken, Executive Secretary
Southwestern Tier Association for the Blind
Jamestown

Lawrence Alexander, Jr., Executive Director*
Neighborhood House Association
Buffalo

Peter Arcangeli, Employment Security Manager
Division of Employment
New York State Department of Labor
Hornell

Lynn F. Banner, County Chairman
Schuyler County Board of Cooperative
Education Services
Watkins Glen

Alice Beardsley, President
Empire State Association for the Deaf
Webster

George Bender, M.D., County Health Commissioner*
Cattaraugus County Department of Health
Olean

Edward L. Bryant, District Supervisor
Division of Vocational Rehabilitation
New York State Education Department
Rochester

Clophas F. Bulleigh, Executive Director
Buffalo Association for the Blind, Inc.
Buffalo

Robert B. Burton, M.D., Director
Medical Program, Sidney Hillman Health Center
Rochester

Frank Butler, Senior Employment Security Manager
Division of Employment
New York State Department of Labor
Buffalo

Roger Butts, Commissioner
Wayne County Department of Social Services
Lyons

John J. Campana, Executive Director
Erie County Chapter
New York State Association for Retarded Children
Buffalo

LaVerne E. Campbell, M.D., Regional Health Director
New York State Department of Health
Buffalo

Angelo J. Cardarelli, Coordinator
Regional Rehabilitation Services
University of Rochester Medical Center
Rochester

Mary F. Champlin, Director of Community Planning
Community Welfare Council of Buffalo and Erie County
Buffalo

Angelo Cid, Probation Consultant*
Division of Probation
New York State Department of Correction
Buffalo

Kenneth Conklin, Personnel Relations Specialist
Buffalo Forge Company
Buffalo

Edward S. Croft, Executive Director
Rochester Jobs, Inc.
Rochester

Albert E. Deemer, Executive Director
Jewish Family Service of Erie County
Buffalo

Gerard J. Diesfeld, M.D., President
Wyoming County Cancer Society
Arcade

Seymour Disraely, Senior Rehabilitation Representative
New York State Workmen's Compensation Board
Rochester

Gilbert Duguay, Executive Director
Niagara County Chapter
New York State Association for Retarded Children
Niagara Falls

Emmett H. Dunlavey, Senior Probation Consultant
Division of Probation
New York State Department of Correction
Buffalo

William Dwyer, Chairman
Monroe County Mental Health Council
Rochester

Barbara Edel, Supervising Nurse
Cattaraugus County Health Department
Olean

Robert F. Ehinger, M.D., Commissioner of Health
Cattaraugus County Health Department
Olean

John Evanko, District Supervisor
Division of Vocational Rehabilitation
New York State Education Department
Buffalo

Roy H. Fabry, Coordinator
Regional Rehabilitation Services
Edward J. Meyer Memorial Hospital
Buffalo

Earl W. Fahy, Executive Director
Rochester Rehabilitation Center, Inc.
Rochester

Otis E. Finley, Jr., Marketing Associate
Eastman Kodak Company
Rochester

Russell F. Forney, Chief Clinical Psychologist*
Rehabilitation Unit, Department of Preventive
Medicine and Community Health, University of
Rochester School of Medicine and Dentistry
Rochester

Robert L. Fox, Commissioner
Livingston County Department of Social Services
Geneseo

Rendle H. Fussell, Area Director
New York State Department of Social Services
Buffalo

Willard Gold, M.D., Director
Mental Health Clinic Services of
Genesee and Wyoming Counties
Batavia

Louis Goldberg, Associate Program Analyst
Division of Local Services
New York State Department of Mental Hygiene
Rochester

Wilfred E. Greenfield, Superintendent
Wellsville Central Schools
Wellsville

William G. Hafner, M.D., Regional Health Director
New York State Department of Health
Rochester

J. Rothery Haight, M.D., Director
Gowanda State Hospital
Helmuth

Roy E. Hatfield, Superintendent
City Mission of Niagara Falls, Inc.
Niagara Falls

Adelaide Hayes, Executive Secretary
Buffalo Association for the Blind
Buffalo

Truxton H. Head, Probation Consultant
Division of Probation
New York State Department of Correction
Rochester

John F. Hickey, Executive Director
Community Welfare Council of Buffalo and Erie County
Buffalo

Betty Hilty, Board Member
National Committee for Multi-Handicapped Children
Sanborn

Gilbert Holtz, Employment Service Supervisor
Division of Employment
New York State Department of Labor
Rochester

David H. Huntington, President
Agricultural and Technical College at Alfred
State University of New York
Alfred

Arnold Jerome, Assistant to the President
St. Joseph's Hospital
Elmira

Kenneth T. Johnson
Attorney at Law
Jamestown

William Joslyn, Superintendent of Schools
Penn Yan

Thomas Kennedy, Executive Director
United Fund and Council of
Southern Chautauqua County
Jamestown

John W. Lange, Director
Rehabilitation Services, Niagara Frontier
Vocational Rehabilitation Center, Inc.
Buffalo

George Lawn, Director
Physical Therapy Department
Women's Christian Hospital
Jamestown

Robert G. Lettis, Executive Director
Council of Social Agencies of Niagara Falls, Inc.
Niagara Falls

Geraldine Looze, Senior Rehabilitation Representative
New York State Workmen's Compensation Board
Buffalo

Victoria C. Markellis, M.D., Commissioner of Health
Orleans, Wyoming and Genesee Counties
Albion

Rozetta McDowell, Regional Director
Western Region, New York State Conference
NAACP
Rochester

Loyal D. McNeal, District Principal*
Warsaw Central School
Warsaw

Harold C. Miles, M.D., Director
Monroe County Department of Mental Health
Rochester

Leon Miller, Area Supervisor
Division of Parole
Executive Department
Rochester

Joseph Mineo, Executive Director
Community Vocational Rehabilitation Center
Niagara Falls

William E. Mosher, M.D., Commissioner
Erie County Health Department
Buffalo

Anthony N. Mustille, Director
Willard State Hospital
Willard

Osborne Myrick, Secretary-Treasurer
Cattaraugus and Allegany County
Labor Union Council, AFL-CIO
Olean

Nelson Nichols, Executive Director
The Buffalo Urban League, Inc.
Buffalo

Lawrence Olnick, Area Director
New York State Department of Social Services
Rochester

Bernard Orzel
Chief Psychiatric Social Worker
Monsignor Carr Institute
Buffalo

Herbert S. Rabinowitz, Executive Director
United Health Foundation of Western New York
Buffalo

Franziska W. Racker, M.D., Director
Rehabilitation Center
Tompkins County Hospital
Ithaca

Francis A. Rauh, General Manager
Capabilities, Inc.
Elmira

John A. Regan, Executive
Monroe County Chapter
National Association for Retarded Children, Inc.
Rochester

Albert C. Rekate, M.D., Director
Department of Rehabilitation Medicine
Edward J. Meyer Memorial Hospital
Buffalo

Charles Ried, President
Cattaraugus County Association
for Retarded Children
Allegany

David L. Roach, Acting Executive Director
Rochester Regional Hospital Council, Inc.
Rochester

Mitchell E. Roth, Executive Director
Hospital Review and Planning Council
of Western New York, Inc.
Buffalo

John P. Rybak, Assistant to the Principal
St. Mary's School for the Deaf
Buffalo

James E. Ryder, Executive Director
Association for the Blind of Rochester
and Monroe County, Inc.
Rochester

Leland C. Sanborn, Superintendent
New York State School for the Blind
Batavia

Edgar J. Schiller, Executive Director
Niagara Frontier Vocational Rehabilitation Center, Inc.
Buffalo

John Seidel, Educational Specialist
National Technical Institute for the Deaf
Rochester Institute of Technology
Rochester

Frank Shelanskey, Member
City of Canandaigua Planning Commission
Canandaigua

T. Merrell Shipherd, Executive Director
Social Planning Council and
United Fund of Tompkins County
Ithaca

George G. Sipprell, Commissioner
Erie County Department of Social Services
Buffalo

Sister Nora, Principal
St. Mary's School for the Deaf
Buffalo

Sister Ann Christine, Administrator
Mount St. Mary's Hospital
Lewiston

Elizabeth J. Smith
Senior Rehabilitation Counselor
Commission for the Blind and Visually Handicapped
New York State Department of Social Services
Buffalo

Leo Snyder, Public Health Educator*
Cattaraugus County Health Department
Olean

Thomas R. Sonne, Chief
Counseling and Training Section
Veterans' Administration Hospital
Canandaigua

Peter Sorensen, Area Supervisor
Division of Parole
Executive Department
Buffalo

Otto J. Stewart, Executive Officer
Board of Cooperative Educational Services
Orleans and Niagara Counties
Medina

Kenneth M. Storandt, Executive Director
Council of Social Agencies of Rochester
and Monroe County, Inc.
Rochester

James A. Sweet, Executive Director
Buffalo Goodwill Industries, Inc.
Buffalo

Roland H. Taft, Administrator
Chautauqua Opportunities, Inc.
Mayville

Norman Utecht, Director
Cattaraugus County Neighborhood
Youth Corps
Olean

Milo Van Hall, Associate Dean
Agricultural and Technical College at Alfred
State University of New York
Alfred

Justin L. Vigdor
Attorney at Law
Rochester

Guy Waters, M.D., Director
Rochester State Hospital
Rochester

William J. Wasmuth, Associate Professor
New York State School of Industrial and
Labor Relations, Cornell University
Ithaca

Herbert W. Watkins
Director of Industrial Relations
Graflex, Inc.
Rochester

Mary E. Wood, Executive Director*
Young Women's Christian Association of
Buffalo and Erie County
Buffalo

William B. Woods, Director
Monroe County Department of Social Services
Rochester

Reverend Alan A. Zielinski, Director*
Monsignor Carr Institute
Buffalo

CONSULTANTS

Muriel Adams
Forestville

George Allen
Corning

Clinton Armitage
Ithaca

Eugene G. Arnold
Ithaca

Donald Beck
Corning

Walter Bell
Buffalo

Frances Berko
Ithaca

Herbert Berry
Buffalo

Dallas E. Billman, M.D.
Corning

Richard Bondi
Hornell

Richard Bornholdt
Watkins Glen

Harry Bowers
Ithaca

Louis Braun
Albany

Robert H. Broad, M.D.
Ithaca

Henrietta M. Brown
Ithaca

Douglass S. Bruce
Corning

Thomas Campiere
Buffalo

Shirley Carkner
Rochester

J. Walter Carlin
Ithaca

Alton Carlson
Salamanca

Fowler M. Carpenter
Elmira

Hugh Carr, Jr.
Jamestown

Helen Chapin
Wellsville

Mary Ellen Cline
Caledonia

Audrey D. Clock
Olean

Sandra Coates
Penn Yan

Edward Cole
Buffalo

Harry C. Cornwall
Ithaca

Thomas Costanzo
Jamestown

Kenneth Cross
Snyder

Donald Culligan
Ithaca

Frances Culliton
Buffalo

Thomas Cummings
Elmira

D. D. Daughety
Ithaca

John Delaney
Hornell

James V. DePonceau
Jamestown

Anna Dingwall
Le Roy

Justin J. Donahue
Elmira

J. Austin Edsal
Horseheads

Donald Ehrhart
Olean

Eugene Erickson
Ithaca

Charles W. Ernst
Buffalo

William Falvey
Penn Yan

Harold E. Farrell
Buffalo

Klaus Feuchtwanger, M.D.
Bath

Willard Gaeddert
Fredonia

Robert Gannon
Buffalo

Paul Guerard
Elmira

Theodore Gundlash
Olean

Lucille Harford
Geneva

Georgia Hartmann
Phelps

Gerard Helper
Buffalo

Arthur Hetrick
Jamestown

William G. Hin
Hornell

A. S. Hinkle
Elmira

Robert Hood
Rochester

Arlene Johnson
Machias

Eunice Jones
Trumansburg

Donald Kamholtz
Olean

Jack Kane
Cheektowaga

Richard Kaufman
Ithaca

Fred Keller
Buffalo

Eugene Kline
Buffalo

Robert C. Kochersberger
Sinclairville

Harry C. Klube
Watkins Glen

Franklyn Kreidler
Little Valley

Leo Kriegbaum
Buffalo

Samuel F. Lanza
Buffalo

Calvin Lauder
Rochester

Reverend Fred F. Leach
Orchard Park

John Leary
Elmira

Reverend Austin Levinski
Watkins Glen

Janet M. Lindner
Buffalo

Philip J. LoGuidice
Fredonia

Reed Lowry
Alfred

John Luensman
Mayville

Theresa Maher
Rochester

Rudy Magnone
Elmira

Claire Marciano
Geneva

Anita M. Marra
Rochester

Charles Martin, M.D.
Niagara Falls

Lloyd McGowan
Sodus

Jane McKeown
Lyons

Martin E. Meier
Jamestown

Dorothea Meyers
Rochester

Robert Milgate
Rochester

William K. Minion
Jamestown

Doris W. Mitchell
Jamestown

John L. Musser, M.D.
Mayville

Sam Nalbone
Jamestown

Earl E. Neurohr
Buffalo

John O. O'Brien
Ithaca

Donald J. O'Connor
Ithaca

Francis O'Rourke
Bath

Everett Olson
Jamestown

Mrs. R.C. Osborn
Ithaca

John Ostanski
Olean

Robert Pasciulla
Lakewood

Alfred L. Perry
Medina

Katherine B. Possee
Watkins Glen

Jess Present
Jamestown

Reverend James Proctor
Albion

Louis A. Radazzo
Alden

Rexford Ransley
Rochester

Kay Reed
Canandaigua

Roger Reger
Buffalo

Garnold L. Richards
Elma

Lionel Richardson, M.D.
Mayville

Lela Robb
Waterloo

Edith B. Robinson
Buffalo

John Rood
Jamestown

Elizabeth Rosebury
Jamestown

Genevieve Shultz
Albion

Elizabeth Schussell
Olean

Lynna Sedlak
Buffalo

William Seneca
Irving

John Shannon
Elmira

George K. Sharpe
Jamestown

Robert Siliciano, M.D.
Elmira

Isador Silverman
Kenmore

Sister M. Aquinas
Elmira

Sister Mary Redempta
Olean

Sister Mary Rene
Hornell

Sister Raphael
Buffalo

Sister Timothy
Olean

Robert R. Sprague
Ithaca

anthony Starr
Ithaca

John Stevenson
Elmira

Mary Stocum
Bath

John S. Stover
Corning

Virginia Sullivan
Buffalo

Harry A. Sultz, DDS
Buffalo

Phoebe A. Thies
Jamestown

Donald Thomas
Buffalo

David Tillum
Olean

Francis V. Tonello
Fredonia

Anthony Torre
Olean

Charles Tracy
Buffalo

Florence Tucker
Elmira

Dean Turner
Tonawanda

Mrs. Marvin Waldman
Ithaca

Mary Waters
Waterloo

Alma Wright*
Rochester

*Resigned

FOREWORD

In the eight months since the Region IV Advisory Committee received its charge to plan for vocational rehabilitation services, there has been widespread community participation throughout the area. Some 400 members and consultants have held approximately 50 meetings at the regional, district, county and task force levels. Contributions have been creative and challenging.

Because the scope of the project is so vast and complex the Regional Report can only attempt an overview of the major recommendations for Statewide Planning for Vocational Rehabilitation. The District and County Reports contain valuable suggestions for concrete action on the recommendations, and have been freely used in preparing the Regional Report. Naturally they differ in emphasis as to their proposals for localized implementation.

There was ready agreement that it is now imperative to extend vocational rehabilitation services to all who need them, as is indicated in the 1968 Amendments to the Vocational Rehabilitation Act. Questions were raised on the feasibility of achieving this total objective by 1975 with the resources and organizational structures likely to be available during the next seven years. For one thing, some of the proposals advanced here involve such far-reaching changes in the existing structure for the planning, administration and delivery of services that the process of change must be gradual to be constructive, and even so may produce tensions associated with significant change in the transitional period. For another, while participants recognized and paid tribute to the historical contributions of groups serving special needs or special subclasses of the disabled and to the organizations created by such efforts, nevertheless, as they have seen their charge, the citizens of Region IV have concluded that precedent is no longer an adequate criterion for relevance of effectiveness. New approaches are essential.

Four major issues have emerged from discussions. Needless to say, unanimity of opinion was not always reached on how these should be resolved. The first is the scope of responsibility, i.e., who is to be served, and to what effect? As viewed by the participants, vocational rehabilitation is a continuum of services offered to disabled people who are beset with medical, emotional, mental and social problems that affect their ability to be gainfully and continuingly employed. As the planning process moved ahead, some people came to think that vocational rehabilitation should not be separated from total rehabilitation. Concomitantly, the opinion was put forward that access to rehabilitation must not be limited to the age span from 16 to 64, as traditionally implemented, but should extend virtually from the cradle to the grave. And it was further reasoned that eligibility should not be restricted to persons with identifiable disabilities. Rather, it should properly include all of the victims of social and cultural neglect such as the rural and urban poor, minority groups, the young, the aged, in fact, all people suffering not only from physical, mental and emotional problems, but also from the inequities and imperfections of the social structure which might impair their present or future economic productiveness.

Some participants, but not all, held that the provision of rehabilitation services need not be limited in its goal to "gainful employment" even under a broad interpretation. They saw as its aim the helping of the disabled and/or disadvantaged individual to achieve an acceptable, personally satisfying pattern of social relationships within his family and his community, and argued that it was sufficiently meritorious to aid him to cope with the elementary problems of self-care. There were some who expressed a belief that rehabilitation methods and concepts should be used to alter the social environment. These persons felt that many of the problems facing some of the disabled, such as the emotionally disturbed, arose not so much from personal pathology as in reaction to stresses unmanageable by them within the fabric of current American society. Suggestions were made that the responsibilities and skills of the vocational rehabilitation counselor should also include preparation to modify the social environment where it seemed to produce or perpetuate handicap.

This latter opinion was reinforced by the growing unrest in urban ghettos and by the increasing awareness of the catastrophic nature and scope of poverty in the midst of national affluence. However, it was not easy to spell out how much of this task fell appropriately within the framework of vocational rehabilitation, especially since many other governmental units and private groups were also striving to deal with various aspects of the needs of the disadvantaged.

It was finally concluded that the Regional Committee's task was to plan for the delivery of services for vocational rehabilitation only, with due recognition as indicated for the strengthening of related medical, social and other human services. Participants did not think that they should restrict their analysis to persons considered capable of engaging in sustained gainful employment. Finally, the view was generally accepted that eligibility should be extended to the families of the handicapped in cases where family members played significant roles in relation to possible service goals.

The Committee did not accept the proposition that membership in a cultural or ethnic minority or a special disability class is necessarily disabling in itself, but affirmed that where such a status does generate a vocational handicap, the individual is a logical candidate for vocational rehabilitation. The 1968

Amendments to the Vocational Rehabilitation Act, P.L. 90-391, now extend to the disadvantaged vocational evaluation and work adjustment programs. The state vocational rehabilitation agency, because of its long and productive experience, was felt by Congress to be best equipped to undertake this mission. This would include preliminary diagnostic studies and adjustment services to insure the ability to follow through on an employment objective.

The second major issue was the focus of responsibility for delivering services. There was general agreement on the suitability of decentralization so that services might be located conveniently (and where advisable, closely) to consumers, especially to the people in greatest need. Questions were raised, however, as to whether administration of such services should be at the local or state level and what the responsibility of each should be. The scattering of resources and effort among a wide array of public and voluntary organizations was noted with concern.

The majority of participants concluded that overall administrative responsibility for vocational rehabilitation must be unified and should remain at the State level to provide for genuine flexibility across organizational, community and county lines. It was also thought that in delivering services the operations should be manned by resident personnel, as opposed to itinerant personnel. At the same time, to further nourish local interest and initiative in achieving positive rehabilitation results, counties and communities should assume the responsibility of providing or developing employment opportunities in conjunction with the development of services, and of improving or establishing adequate local facilities. Active assistance from the State would be anticipated in each area.

The third issue had to do with the future of generic and specialized agencies. Many specialized agencies, such as those serving the blind and deaf, were among the pioneers of vocational rehabilitation. These and other groups concerned with the crippled and the mentally retarded, have contributed vastly to knowledge in their fields and have made possible the development of standards, and programs of great merit and high quality. In urging the concept of multi-disability integration of services these contributions were gratefully recognized. However, most participants believed that a blow had to be struck against the fragmentation of services along specialized agency lines or by disability types where not essential if a truly rational solution were to be found for the problem of reaching as many of the vocationally handicapped as possible.

Finally, there were substantial differences over the question, "Are some services better than none?" One faction argued that agreement might encourage the multiplication of non-professional staff and stop-gap measures which would be unable to ensure achievement of effective vocational rehabilitation programs. Others felt that undue emphasis might be placed on self-justifying professional standards and models for professional practice which even now are open to critical inquiry. It was generally accepted that strong, innovative recommendations were needed in coping with the shortages of rehabilitation manpower and of facilities. These were set forth not in hope of producing a crop of "ninety-day wonders", but to provide more experimental approaches and these to be carefully and continuously studied through State consultative programs. Perhaps by such enterprises fresh and better solutions to the problems of manpower and facility shortages may be found.

Isabel Boner
Regional Planning Director

PROFILE OF THE REGION

Region IV includes the 18 counties in the westernmost part of New York State with approximately 3,000,000 population, about 17 percent of the State's total. For the purpose of this study the Region has been divided into four Districts which may be referred to loosely as the Buffalo District (6) including Erie, Genesee, Niagara, Orleans and Wyoming counties; the Jamestown District (7) comprising Allegany, Cattaraugus and Chautauqua; the Elmira District (7-A) with Chemung, Schuyler, Steuben and Tompkins counties; and the Rochester District (8) including Livingston, Monroe, Ontario, Seneca, Wayne and Yates counties. (See Map 1, p. 323)

The three major cities, Buffalo, Rochester and Niagara Falls, are in the northern part of the Region on Lakes Erie and Ontario. The southern tier contains a series of small cities distributed at intervals along the southern fringe, the largest of which are Jamestown, Olean, Hornell, Corning and Elmira. Ithaca in Tompkins County, near the middle of the eastern border of the region, appears to be linked for many purposes more closely with Syracuse, and in most planning studies is considered logically to be a part of Region III. The central part of the Region is predominantly rural, having no major population centers. Rehabilitation services are concentrated on the periphery of the region; the central and southwestern sectors are virtually undeveloped in this respect. The Region contains 79 hospitals with 29,000 beds. Region IV contains six counties of less than 50,000 population and three of them, Allegany, Schuyler and Yates have an average of per-capita income of less than $2200. (See Map 3, p. 324)

The two large cities of Buffalo and Rochester, while they have many characteristics in common, differ in the unemployment rates anticipated by 1975. Buffalo is likely to find a significant increase in the unemployment rate by 1975.[1] Rochester, on the other hand, is one upstate community that is expected to have a substantial increase in job openings by 1975. Its unemployment rate is expected to drop.

The metropolitan areas of Buffalo and Rochester are linked by the New York State Thruway and circled by partially-completed belt routes. By 1975 we can anticipate that the southern-tier towns and cities will have improved interchange through the completion of the Southern Tier Expressway and lateral expressways from north to south joining these two east-west expressways. Air routes provide easy access to and egress from Buffalo and Rochester eastward, but scheduled air flights southward and southeastward are limited. Many small towns in the central area of the State are not on bus routes and have no access to any form of public transportation. The development of a better highway system, or even the improvement of public transportation systems would not, in themselves, provide a solution to the transportation of the handicapped requiring rehabilitation services. Undoubtedly they would serve as a spur to commerce and industry, but clients, both in the rehabilitation process and in many instances after rehabilitation, will require special transportation services.

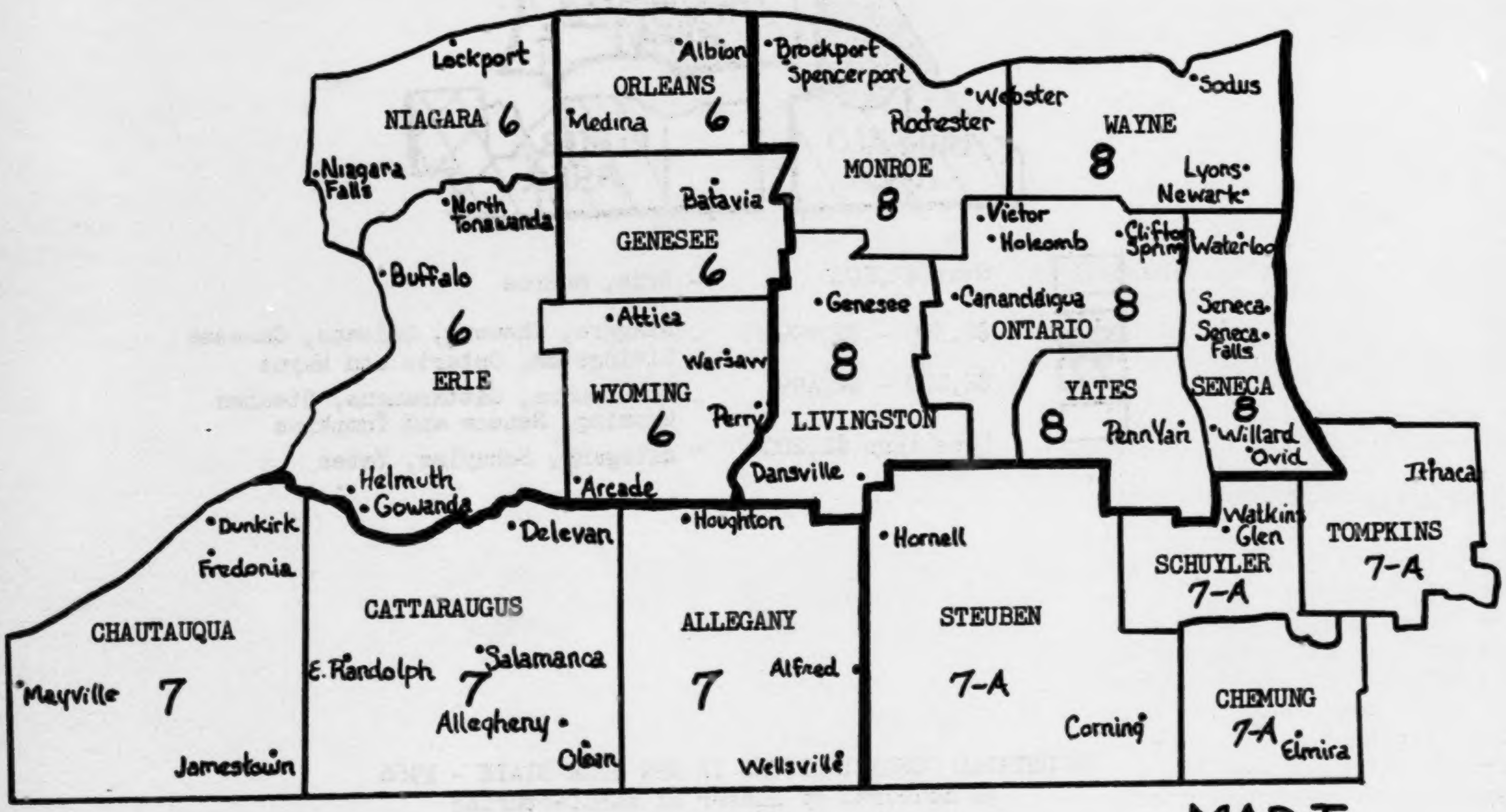
The social and economic problems typical of metropolitan areas are concentrated in the cities of Buffalo and Rochester. The smaller cities have not yet felt the impact of the crises created by the development of ghettos. Yet the magnitude of the problem of the rural poor would appear from the Committee's observations to be a major one in Region IV. These are mainly scattered and inarticulate people whose numbers are growing as the agricultural component in the economy diminishes. Already in the southern Erie County pockets of poverty are developing as seasonal agricultural workers settle into local communities. (See Map 2, p. 323)

Minority groups in the Region having their separate cultural identities and isolated from the mainstream of community life include the Negro, Indian, migrant worker and the Puerto Rican. The Negro population is concentrated in the cities of Buffalo and Rochester, the latter having the fastest-growing Negro population in the State. Erie, Monroe, Orleans and Niagara are the counties having the largest percentage of non-white population - more than 4 percent, and it will be noted that these counties are contiguous to metropolitan areas. In Chautauqua County the city of Jamestown has one small ghetto, but the rural poor are predominantly white.

Indians living on reservations are concentrated in the northwestern and southwestern parts of the State. The Region contains approximately 6,000 of the 10,000 Reservation Indians in the State of New York. They are in the counties of Cattaraugus, Chautauqua, Erie, Genesee and Niagara. A representative of the Seneca Nation has been a consultant to the Regional Advisory Committee and reports that problems on reservations in general parallel those of the white population, including a growing school dropout rate. Some of the Nations are beginning to develop small industries on the reservations. With the closing of reservation schools and the integration of Indian children into the public school systems, the members of the various Nations are beginning to seek a more active role in policymaking on local school boards.

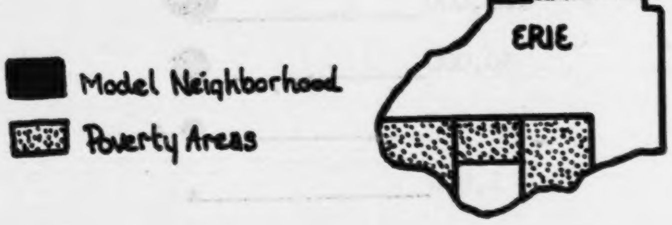
Region IV has a large migrant worker population. With the decline of agriculture in the economic structure the number of migrant workers has steadily declined. Many have moved to the cities or other urban areas in the Region. Puerto Rican colonies exist in several parts of the Region, notably in Lackawanna, where displaced farm workers have sought employment in the steel industry.

REGION IV


Lockport
NIAGARA 6
Niagara Falls
North Tonawanda
Buffalo
6
ERIE
Albion
ORLEANS
Medina 6
Brockport
Spencerport
Webster
Rochester
MONROE
8
WAYNE
8
Sodus
Lyons
Newark
Batavia
GENESEE
6
Attica
Warsaw
WYOMING
6
Perry
Arcade
Genesee
8
LIVINGSTON
Dansville
Victor
Holcomb
Clifton Springs
Waterloo
Canandaigua
ONTARIO
8
Seneca
Seneca Falls
SENECA
8
YATES
8
Penn Yan
Willard
Ovid
Ithaca
TOMPKINS
7-A
Watkins Glen
SCHUYLER
7-A
Helmuth
Gowanda
Dunkirk
Fredonia
CHAUTAUQUA
Mayville
7
Jamestown
Delevan
CATTARAUGUS
E. Randolph
7
Salamanca
Allegheny
Olean
Houghton
ALLEGANY
Alfred
7
Wellsville
Hornell
STEUBEN
7-A
Corning
CHEMUNG
7-A
Elmira

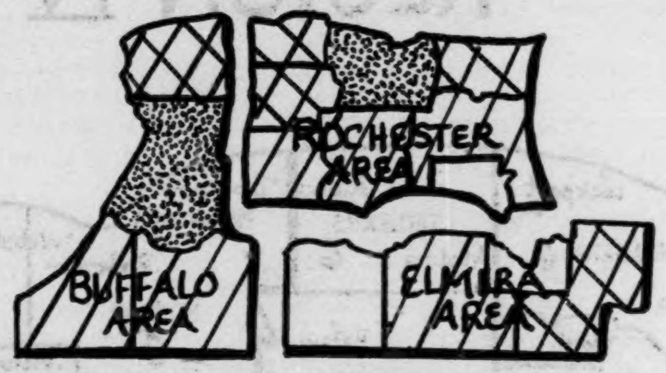
MAP I

BUFFALO LABOR AREA


NIAGARA
City of Niagara Falls
City of Buffalo
Lackawanna
ERIE
Model Neighborhood
Poverty Areas

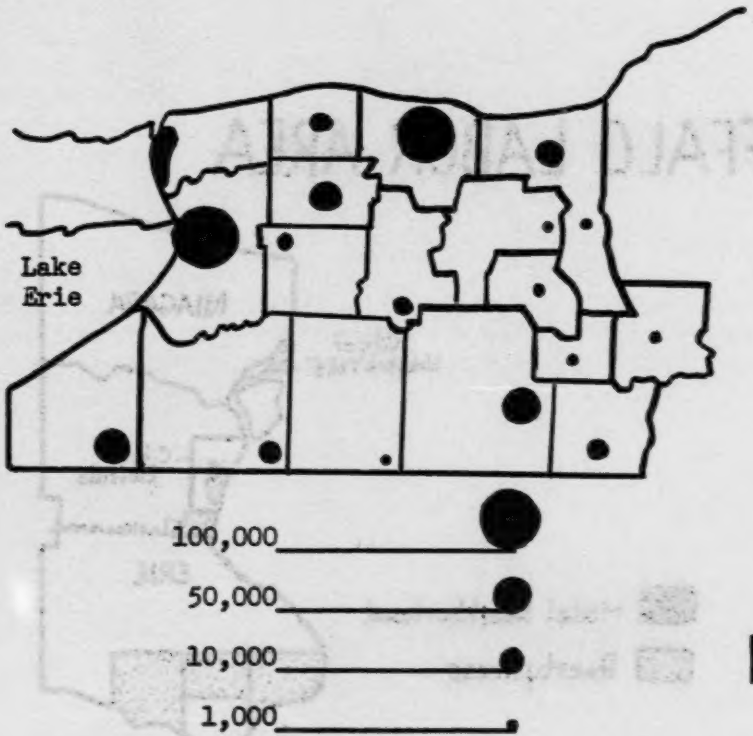
MAP II

PERSONAL INCOME PER CAPITA IN COUNTIES OF NEW YORK STATE - 1965


ROCHESTER AREA
BUFFALO AREA
ELMIRA AREA

░	Over $2,800	- Erie, Monroe
▩	$2,500 - $2,799	- Niagara, Chemung, Orleans, Genesee Livingston, Ontario and Wayne
▨	$2,200 - $2,499	- Chautauqua, Cattaraugus, Steuben Wyoming, Seneca and Tompkins
☐	Less than $2,200	- Allegany, Schuyler, Yates

INDUSTRIAL CONCENTRATIONS IN NEW YORK STATE - 1966
As measured by number of manufacturing
employees covered by unemployment insurance


Lake
Erie
100,000
50,000
10,000
1,000

MAP III

In some studies the rural poor have been referred to as an "invisible population." They cannot be identified as a distinctive group. County welfare rolls do not accurately reflect the number of the rural poor, since displaced agricultural workers frequently tend to subsist on a minimal income eked out through sporadic employment without seeking public assistance. The isolated rural poor are less aware of available rehabilitation facilities and are more limited in access to such facilities because of transportation difficulties. There is evidence that these two groups, the urban poor and the rural poor, have a higher incidence of disability than the general population. Nonwhites predominate in the urban poverty areas and National Health statistics show that nonwhites reported 25 percent more total limitations of activity than whites during the fiscal years 1962-63.[2] The rural farm population has the highest incidence of disability of all groups - 15.4 percent, as compared with 9.8 for residents of the larger metropolitan areas. [3]

Although the major cities, Buffalo and Rochester, have a variety of resources for vocational rehabilitation programs, there are significant gaps in available services. Unresolved coordination and transportation problems have resulted in overlapping services and programs on one hand, and patterns of underutilization on the other. Gaps in service appear, for example, in the availibility of adequate treatment facilities in Buffalo for alcoholics, and in the entire region for drug addicts. Outside the immediate radius of the two large metropolitan areas all services are scattered and uneven.

Of the three types of agencies directly concerned with vocational rehabilitation, such as comprehensive vocational rehabilitation facilities, Primary and Secondary Rehabilitation Centers, and Workshops, the Region contains a total of 23. The five comprehensive facilities (A comprehensive facility is defined here as one offering the basic services of vocational evaluation, personal adjustment training and vocational training.) are the Niagara Frontier Vocational Rehabilitation Center, Buffalo Goodwill, Inc., Community Vocational Rehabilitation Center in District 6; the Rochester Rehabilitation Center in District 8; and Capabilities, Inc. in Elmira. District 7 in the southwestern part of the Region, contains none. A sixth comprehensive facility is projected for Ithaca. The five agencies offer a full gamut of rehabilitation services and have no rigid geographical limits. However, in practice, transportation difficulties, lack of residential facilities, and reluctance of clients to travel impose formidable barriers to access for clients from the remote counties. It became apparent also in the course of the Committee's study that many professionals in the fields of health, social services and education do not refer clients because of a limited understanding of the functions and the scope of the state and private rehabilitation departments and facilities, another factor which contributes to the underutilization of existing facilities.

Region IV contains two primary and four secondary rehabilitation centers designated by the State Health Department. The primary centers are at E.J. Meyer Memorial Hospital in Buffalo and the University of Rochester Medical Center. The secondary centers are at Mt. St. Mary's in Lewiston, WCA Hospital in Jamestown, St. Joseph's Hospital in Elmira and Tompkins County Hospital on the eastern fringe of the Region and linked to a primary center in Syracuse which is in Region III. The primary centers also offer the basic services of vocational evaluation, personal adjustment training, and vocational training through hospital-based occupations. The secondary centers, however, do not offer all of these vocational services.

Long-term sheltered employment is recognized as a legitimate and necessary rehabilitation service. Workshops affording long-term sheltered employment in District 6 include Goodwill Industries, Community Vocational Rehabilitation Center in Niagara Falls and the Association for the Blind in Buffalo. The Association for Retarded Children workshops in Buffalo and in Niagara Falls are small and should be expanded to serve a variety of disability groups. District 7 has four small facilities affording work activity, but these cannot properly be designated as workshops. They are at Falconer, Dunkirk, Jamestown and Olean. Districts 7-A and 8 each have two small facilities which are not complete workshops either.

It is apparent that the lack of adequate facilities combined with the relatively low number of clients shows that there is need for more workshop facilities to serve the work-handicapped of Region IV. As a point of emphasis, information gathered by the Statewide Planning Committee for Facilities and Workshops indicates the complete absence of facilities meeting appropriate standards for workshops in 14 of the 18 counties of Region IV.

We see a direct correlation between the small numbers served and the paucity of available resources. The shortage of services in these counties is further emphasized when one takes into consideration the numbers actually served in 1967 and contrasts them with estimates of the numbers of disabled individuals in these counties unable to perform their major activity because of a handicapping condition.

ESTIMATES OF DISABILITY

In the present state of the science identifying the numbers and the types of the disabled is at best a process of educated conjecture.

Projections show that the population of Region IV will be 3,330,105 by 1975. A preliminary estimate indicates that 77,729, or 2.3 percent, will be limited in their ability to perform their major function.[4] Since a total of only about 7,500 in the Region received services from the state rehabilitation agencies in 1967, there is no question that the population in need has been dramatically underserved. Region IV has the second highest percentage (about 2.3 percent) of those with limitation of function in the State. Region I, including New York City, has the highest, with 3 percent according to the estimates. These figures include only those handicapped who might have been considered eligible for vocational rehabilitation in the past, and do not include other populations, such as the aged, the young, the institutionalized, and the disadvantaged. The emotionally disturbed and mentally retarded are very much underestimated.

RECOMMENDATIONS

Administrative Regrouping of Vocational Rehabilitation Resources

The Committee found that "the capabilities and capacity of (existing) facilities are inadequate to meet the needs of an expanding and more complex client population eligible for services. While present policy provides opportunities to establish reasonably autonomous units on a county-by-county basis, there is evidence that the merging of services, particularly of the professional staff, will become an economic necessity. Further, there appears to be certain cost advantages which would accrue by consolidating certain services for clients which now tend to be highly proliferated, i.e., personal adjustment training, placement efforts, etc. In order to help alleviate the acute shortage of personnel, it appears that great cooperation and pooling of resources will be essential in the future." (District 7-A Report)

The four districts in Region IV attacked the problem of consolidation of existing agencies and reorganization of the existing structure in various ways. In some counties, the Advisory Committee has found the local legislative and administrative bodies highly responsive when the need for new or expanded services was clearly demonstrated. But this was not universally true. The Committee therefore presents the following proposal for regrouping of resources:

> A STATE DEPARTMENT OR OFFICE OF VOCATIONAL REHABILITATION SHOULD BE ESTABLISHED UNDER THE IMMEDIATE AUTHORITY OF THE GOVERNOR OF THE STATE OF NEW YORK.
>
> Under the Constitution of the State of New York, the number of departments is limited to 20. The creation of a new department would require a constitutional amendment, and is not imperative. A State Office of Vocational Rehabilitation is suggested as more feasible at this time under the direct jurisdiction of the Governor and reporting to him. Such an office would consolidate the rehabilitation functions of the eight major departments and 30 or more units within state government now involved with rehabilitation programs of various kinds. It would offer a coordinated program and create a continuum of services for preschoolers through the aged, utilizing existing services, eliminately duplications and filling in gaps in services. It is proposed that the first step in consolidation of existing rehabilitation agencies should be a merging of the Division of Vocational Rehabilitation and the Commission for the Blind and Visually Handicapped.

In order to ensure that such a State Office will have the benefit of consultation from industry, voluntary agencies, labor and the interested public, the Committee recommends:

> A PERMANENT STATE ADVISORY COMMITTEE ON REHABILITATION SHOULD BE ESTABLISHED.
>
> In order to encourage and permit the greatest local participation in the development of improved rehabilitation services on a statewide basis, such an Advisory Committee to the designated State Vocational Rehabilitation Agency should be set up. Representation on this Committee can be selected by means to be devised at a later time, but giving strong emphasis to local expression of need and to solutions of rehabilitation problems.

Because of the need for continuous planning and for implementation of the recommendations made by the Committee and future planning bodies, for research and pilot projects to develop new techniques and services, and for simplification of methodologies and for coordination of services,

> THE COMMITTEE RECOMMENDS THE CREATION OF A PERMANENT PLANNING SECTION IN THE STATE VOCATIONAL REHABILITATION AGENCY.

In order that services may be delivered to locations most in need of them, and for the purpose of encouraging local participation in the planning process, it is recommended that:

> LOCAL OFFICES OF THE STATE VOCATIONAL REHABILITATION AGENCY SHOULD BE ESTABLISHED IN EACH COUNTY OR IN LARGER COMMUNITIES WHERE CURRENT OR ANTICIPATED CASELOADS WARRANT A VOCATIONAL REHABILITATION OFFICE. THIS LOCAL OFFICE SHOULD BE MANNED BY RESIDENT AS OPPOSED TO ITINERANT PERSONNEL.
>
> Such offices could be well established in the same locations as those of the State Employment Service and should coordinate closely with employment offices as well as local voluntary agencies to achieve a maximal placement effort as well as optimum utilization of resources.

In other cases, different groupings should be developed. Because of recognized inadequacies in the numbers and locations of workshop facilities in Region IV and in order to maximize workshop services to the greatest number of all disabled in the Region, the following recommendations are made:

- EXPANSION OF THE COMPREHENSIVE VOCATIONAL REHABILITATION CENTER, BUFFALO, TO SERVE SATELLITE WORKSHOPS IN THE FOLLOWING AREAS: AMHERST, CLARENCE, AKRON, HAMBURG, ORCHARD PARK, EAST AURORA, GOWANDA AND SPRINGVILLE.
- THE EXPANSION OF COMMUNITY VOCATIONAL REHABILITATION CENTER, NIAGARA FALLS, TO SERVE A SMALL WORKSHOP LOCATED IN LOCKPORT.
- THE ESTABLISHMENT OF A NEW COMPREHENSIVE VOCATIONAL REHABILITATION FACILITY IN JAMESTOWN TO SERVE THE TRI-COUNTY AREA AND SMALL WORKSHOPS IN CHAUTAUQUA, CATTARAUGUS AND ALLEGANY COUNTIES.
- THE ESTABLISHMENT OF A NEW COMPREHENSIVE VOCATIONAL REHABILITATION FACILITY IN GENEVA TO SERVE THE RESIDENTS OF WAYNE COUNTY, ONTARIO, SENECA AND YATES COUNTIES AND SUPERVISING SATELLITE WORKSHOPS LOCATED IN OUTLYING AREAS OF THE SAME COUNTIES.
- THE EXPANSION OF CAPABILITIES, INC. IN ELMIRA, TO SUPERVISE SATELLITES IN THE COUNTIES OF SCHUYLER AND STEUBEN.
- AN EXTENSION OF THE SERVICES OF THE ROCHESTER REHABILITATION CENTER TO INCLUDE REMEDIATION SERVICES AND TO SUPERVISE SATELLITE WORKSHOPS IN GENESEE, LIVINGSTON, AND WESTERN ONTARIO COUNTIES AND THE OUTLYING AREAS OF MONROE COUNTY.

In order to re-emphasize the ultimate objective of the rehabilitation process which is placement either in a competitive work situation, in a sheltered workshop, in a home industry or as a homemaker, it is recommended that

THE TITLE OF PLACEMENT COORDINATOR BE DEVELOPED WITHIN THE STATE REHABILITATION AGENCY.

Eligibility criteria for such positions are discussed elsewhere in this report under "Administrative Aspects."

The Committee recommends that

EDUCATIONAL PROGRAMS BE MADE AN INTEGRAL PART OF THE REGIONAL REHABILITATION CENTERS.

Such programs should provide not only for in-service training of regional staff but also for training local rehabilitation staff, and should include periodic symposia to educate staff of other community agencies, personnel staff from industrial plants and other interested community personnel. Such programs would encourage the referral of persons in need of vocational rehabilitation services from all sources.

One of the methods for bringing services to small communities and rural areas is to develop itinerant teams of professionals who would visit remote populations on a regular basis in a special mobile unit equipped to render services not available locally.

IT IS RECOMMENDED THAT THE CONCEPT OF THE REHABMOBILE BE IMPLEMENTED WITH STRONG IDENTIFICATION WITH LOCAL FACILITIES AND OPERATED IN CONJUNCTION WITH A CLIENT TRANSPORTATION SYSTEM.

Rehabmobiles should encourage client participation in established programs and workshops, develop community interest in rehabilitation, and enhance services. To forestall agency competition for clients, administrators would make judgments as to whether clients would be served by rehabmobilies or through a transportation service to facilities.

At the present time only one rehabilitation agency in the Region has a residential facility. This residence is not sufficient to house clients from adjoining counties in need of services. While the Committee is primarily concerned with decentralizing workshops and facilities and bringing services to the client, there will always be a need for residential facilities at the proposed centers. Therefore the Committee recommends that

FINANCIAL SUPPORT BE MADE AVAILABLE FROM STATE FUNDS OR AUTHORITIES FOR THE CONSTRUCTION OF RESIDENTIAL FACILITIES FOR THE HANDICAPPED CONVENIENT TO REHABILITATION CENTERS AND OTHER VOCATIONAL TRAINING FACILITIES.

The preliminary report of the Workshops and Facilities Survey indicates that certain facilities are underutilized. Still others report that they have no waiting lists although it is apparent that there are many individuals in the community in need of their services. A major factor contributing to this underutilization is the lack of transportation facilities. Therefore the Committee recommends that

> FUNDS FOR TRANSPORTATION FACILITIES AND SYSTEMS BE MADE AVAILABLE THROUGH THE STATE VOCATIONAL REHABILITATION AGENCY AND/OR THROUGH POOLED RESOURCES OF THE STATE AGENCIES FOR HEALTH, MENTAL HEALTH AND VOCATIONAL REHABILITATION AND THROUGH COORDINATION WITH VOLUNTARY AGENCIES.

DISABILITY RECOMMENDATIONS

The Blind

Using the generally accepted rate of 1.9 per 1,000 population, it is estimated that there will be 6,249 blind persons in the Region by 1975. These are the legally blind, not all of whom are registered. In 1967 there were 4,093 registered blind in the Region of an estimated 5,757, indicating that the blind registry as constituted accounts for only about 70 percent of the actual blind. An additional 3.7 persons per 1,000 population are visually handicapped. Yet there were only 328 cases in the Region active with the vocational rehabilitation services of the Commission for the Blind and Visually Handicapped in February, 1968. A Task Force Report on the Blind describes the available services in Region IV, the needs, problems and suggested solutions. Of particular significance in the Task Force Report is the fact that of a group of 50 recent referrals for vocational rehabilitation services only three were from eye physicians, although they are required by law to report the blind cases they examine. Most of the 955,000 blind in the United States are 58-80 years of age; only two percent are children under 18. Yet almost all services are offered to children and young employable adults.

> ONLY ONE STATE AGENCY SHOULD BE INVOLVED IN THE DELIVERY OF VOCATIONAL REHABILITATION SERVICES TO ALL HANDICAPPED REGARDLESS OF THE NATURE OF THE HANDICAP.
>
> The peculiar nature of certain handicaps, such as the blind and the deaf, require specialists within the counseling field who must be recruited and/or receive special training, but it will be advantageous to have only a single administration.
>
> VOLUNTARY AGENCIES MAINTAINING WORKSHOPS FOR THE BLIND SHOULD BE ENCOURAGED TO EXTEND SUCH SERVICES TO PERSONS WITH OTHER HANDICAPS.
>
> The Committee suggests that specialized workshops for the blind tend to perpetuate isolation and limit the potential of the blind individual. The integration of blind persons in facilities with other disabled persons and with sighted people is highly desirable. It is essential that such agencies, when they become generic, continue to be staffed with personnel having a high degree of competence in work with blind persons. Such staff should be ready to provide consultation and special assistance when particular problems arise. Their serivces should also be utilized in interpreting the problems and potential of blind persons to school personnel, to employment personnel and to employers.
>
> In the area of sheltered work it is possible that a special work facility could be maintained for very severly limited persons who would not be capable of functioning alongside their non-blind peers.
>
> VOLUNTARY AGENCIES FOR THE BLIND SHOULD PUT GREATER EMPHASIS ON AND PROVIDE STAFF FOR THE FOLLOWING PROGRAMS:

- Counseling of family members
- Mobility instruction and personal care
- Communications and writing skills
- Social and recreation programs- not specifically for the blind but to encourage inclusion of the blind in integrated community programs and school activities
- Homemaking activities
- Programs for the elderly

THE STATE SCHOOL FOR THE BLIND IN BATAVIA SHOULD BECOME A FULL-SPECTRUM FACILITY.

Diagnostic, vocational training, placement and follow-up services should be introduced, as well as a blind registry. This facility should be expanded to serve the multiply-handicapped blind and should work closely with the nearby comprehensive rehabilitation centers.

THE STATE EDUCATION DEPARTMENT SHOULD STRENGTHEN THE REPORTING SYSTEM TO ENSURE THAT ALL BLIND PERSONS ARE DULY REGISTERED.

Since the Education Department is the licensing agency for such professionals, this agency should take the initiative to inform and educate these persons in order to ensure more complete registration.

EXPAND THE TALKING BOOK PROGRAM TO INCLUDE A SMALL EARPHONE AND JACKPLUG FOR PRIVATE LISTENING.

This addition would enable the listener to use the machine without interfering with other family activities. This service should be available not only to the blind, but also to the physically handicapped who may benefit from such devices.

The Deaf

Statistics on the deaf have been difficult to come by. No categorical definition of deafness comparable to the definition of legal blindness had been established until the recent Temporary State Commission for the Deaf undertook to do so. The report of the Commission[6] states that there are 111,206 persons in the State suffering from severe binaural hearing loss, and estimates that there are 3.8 persons per 1,000 population who cannot hear or understand spoken words. National Health Statistics for the State show that by 1970, in the number of chronic conditions among persons unable to carry on their major activity, 21,762 will have hearing impairments. This compares with 63,408 persons having visual impairments.[7] Except for the metropolitan areas of Buffalo and Rochester, facilities for the deaf are limited in Region IV.

There is a shortage of specialized vocational rehabilitation facilities for the deaf in Region IV. Specialized education facilities do not exist, including pre-school programs and special classes for hearing impaired children in public and private schools. There are also two special schools in Region IV for the profoundly deaf: St. Mary's School for the Deaf in Buffalo, and the Rochester School for the Deaf in Rochester, one state-supported and the other state-operated. The National Technical Institute for the Deaf is located in Rochester and provides technical training at an advanced level for deaf students recruited from the entire country on a selected basis. Adult education for the deaf is practically non-existent throughout the State.

According to the Education Committee of the Temporary State Commission for the Deaf, the most pressing needs in education are for cooperation and coordination of the diversified public education programs with the state-supported schools for the deaf, additional state funds for the support of nursery schools as federal funds are gradually withdrawn, accreditation of the high school programs for the deaf, and development of adult education programs. To serve the multiply-handicapped deaf, a State University program for the training of specialists in education of the deaf needs to be developed, as well as more diagnostic and educational centers for such children.

Vocational rehabilitation services for the deaf are provided at only three of the five comprehensive rehabilitation facilities in the Region: the Rochester Rehabilitation Center, Niagara Frontier Vocational Rehabilitation Center, and Buffalo Goodwill. All five facilities provide services for the hard of hearing, according to the State Workshops and Rehabilitation Facilities Inventory of 1967. It is recommended that

THE COMPREHENSIVE COMMUNITY REHABILITATION CENTERS WHICH ARE TO BE ESTABLISHED THROUGHOUT REGION IV ALSO INCLUDE A WIDE RANGE OF INFORMATION AND REFERRAL SERVICES AVAILABLE TO DEAF PEOPLE WHO HAVE NEEDS OF A VOCATIONAL AS WELL AS A NON-VOCATIONAL NATURE.

Speech and Hearing Clinics of the Region are functioning in Buffalo, Rochester, Lockport, Jamestown, Fredonia, Elmira and Ithaca. These centers provide in varying degrees hearing evaluation, hearing-aid selection, otological examinations, psychiatric, psychological and social evaluation, social and recreation services, parent counseling, and vocational planning. These programs are financed through the New York State Department of Health, university programs, and private agencies.

The Region IV Committee recommends that

> A PLAN BE DEVELOPED BY THE STATE REHABILITATION AGENCY FOR TRAINING SPECIALISTS IN TECHNIQUES SPECIFIC TO THE NEEDS OF THE DEAF.
>
> Comprehensive Statewide Planning staff has been working with State vocational rehabilitation agencies, and upstate voluntary agencies in planning an expanded program of services to the blind. This will be a direct professional training program sponsored jointly by Comprehensive Statewide Planning and the Social Rehabilitation Services Research and Training Center of Johnstown, Pennsylvania. A similar program should be sponsored for the deaf. This would provide trained specialists who would work in generic vocational rehabilitation facilities and in sheltered workshops, giving special attention to the problems of the deaf. It has been proposed by District 8 that the University of Rochester, located near the National Technical Institute for the Deaf, the Al Sigl Center, the Medical Center, the Hearing and Speech Center for the Deaf, and the Rochester School for the Deaf is the logical site for the development of a graduate training program in speech and hearing.

The Mentally Ill

Planning for Mental Health Services is an ongoing process under the New York State Community Mental Health Services Act. Representatives from State, County and voluntary mental health agencies have taken an active part in Statewide Planning for Vocational Rehabilitation. Community Mental Health Centers have been established or are in the planning stage for most of the catchment areas in the Region. The new construction program for rehabilitation centers in 13 State hospitals will provide vocational rehabilitation programs in these centers.

It is increasingly recognized that a major problem in rehabilitating mentally ill persons has to do with the ways that services are currently delivered by the many agencies and groups serving the emotionally disturbed. One difficulty arises from the patterns of professional practice used by these agencies, which appear to lack flexibility in relation to changing community needs. Secondly, there is an ever-increasing manpower shortage in the mental health field which traditional approaches to mental health manpower development have not succeeded in overcoming. If these two difficulties are not dealt with in fresh and imaginative ways, we must look forward to a widening gap between the mentally ill persons who are reaching out for services, and our ability as community resources to aid them.

> PATTERNS OF ORGANIZED, AGENCY-BASED PSYCHIATRIC CARE WHICH HAVE BEEN DEVELOPED LARGELY IN TERMS OF URBAN MIDDLE CLASS EXPERIENCES, MUST BE SERIOUSLY RECONSIDERED SO THAT MORE EFFECTIVE AND MORE READILY ACCESSIBLE SERVICES ARE MADE AVAILABLE TO RURAL POPULATIONS WITH RESPECT TO INTAKE, EMPLOYMENT, FOLLOW-UP AND PARTIAL HOSPITALIZATION PLANS.

The Committee is also concerned with the fact that delays in the employment of discharged mental patients capable of working may lead to readmission, and therefore recommends

> AN INTENSIVE JOB DEVELOPMENT PROGRAM BE ESTABLISHED AT STATE HOSPITALS AND THAT PLACEMENT COORDINATORS BE ASSIGNED ON A FULL-TIME BASIS TO EVERY STATE HOSPITAL TO DEVELOP PLACEMENT OPPORTUNITIES THROUGH THEIR OWN EFFORTS AND THROUGH COORDINATION WITH THE NEW YORK STATE EMPLOYMENT SERVICE.

The Committee also recommends

> PROVISION OF RESIDENCES, OR HALF-WAY HOUSES IN LOCATIONS CONVENIENT TO JOB SITES. SUCH RESIDENCES SHOULD NOT BE RESTRICTED TO EX-MENTAL PATIENTS ONLY, BUT SHOULD BE UTILIZED BY OTHER HANDICAPPED PERSONS AS WELL.

The Mentally Retarded

New York State Department of Education figures show approximately 8,084 mentally handicapped children enrolled in public schools in the 18 counties of Region IV in the 1966-67 school term. Erie County alone had 2,681. The State Workshops and Rehabilitation Facilities Inventory shows a total of 128 adult retarded served in three specialized workshops operated by the ARC in Niagara, Erie and Monroe Counties in 1966-67. An estimated 500 additional persons were served in the workshops operated by Buffalo Goodwill, NFVRC, CVRC, and Capabilities, Inc. Thus it would appear that approximately 628 retarded received vocational rehabilitation services or workshop employment, yet there were roughly 46,000 people in the Region unable to carry on their major activity due to mental retardation in 1965. The mentally retarded, in addition to their intellectual limitations, have perhaps a greater problem in terms of social relationships than other handicapped. The problem of socialization in this group is severe, and the lack of it can lead to psycho-social complications which aggravate the intellectual limitations. In recent years greater educational opportunities have been provided for the educable retarded, and it has been demonstrated that members of this group are more easily placed in comparison with certain other handicapped individuals. Some of the mentally retarded have been placed in jobs below their capacities without taking due account of their true potential.

It has been suggested in the Tompkins County Report that special classes in the public schools should extend their services to include a work-study approach which would take the educable out on the job on a pre-apprentice basis at as early an age as possible. Classroom preparation and conditioning would have to be tied to the motivation that would hopefully come from the knowledge of the opportunity to have a "work" tryout. This suggests the obvious need for a close working relationship between a special class program and both a work-training center and an on-the-job training program. It also suggests the ultimate objective of developing more of the "workshop" factors in the special class setup.

> THE COMMITTEE RECOMMENDS THAT ALL STATUTORY REGULATIONS BE REMOVED THAT WOULD PREVENT BOCES FROM FORMING A RELATIONSHIP WITH NEARBY COMPREHENSIVE REHABILITATION CENTERS TO PROVIDE VOCATIONAL TRAINING, PERSONAL ADJUSTMENT TRAINING, AND JOB EVALUATION WHICH WOULD LEAD TO THE DEVELOPMENT OF THE MAXIMUM POTENTIAL OF RETARDED AND OTHER HANDICAPPED CLIENTS.

Recognizing that certain retarded individuals cannot achieve the level of employment in competitive industry and that such individuals will require a sheltered environment,

> THE COMMITTEE RECOMMENDS THAT EXISTING WORKSHOPS FOR THE MENTALLY RETARDED BE EXTENDED TO INCLUDE OTHER DISABILITIES, THUS AFFORDING WORKSHOP EMPLOYMENT TO MORE OF THOSE HANDICAPPED WHO CANNOT COMPETE IN PRIVATE INDUSTRY.

> FOLLOW-UP SERVICES, INCLUDING FAMILY CASEWORK SHOULD BE INTENSIFIED FOR THE RETARDED CLIENT DURING THE FIRST YEAR OF EMPLOYMENT.

> Such follow-up would serve to conserve positive attitudes and resolve problems relating to the work situation, and to family adjustment. It would mitigate the possibility of frequent job turnover.

The Socially and Culturally Disadvantaged

Considerable discussion developed during the planning process in Region IV as to the role to be played by public and voluntary vocational rehabilitation agencies in relation to the disadvantaged. The position of the Committee is stated in the Foreword to this report. The 1968 Amendments to the Vocational Rehabilitation Act make it possible for the state vocational rehabilitation agencies to provide personal adjustment training and vocational evaluation services to this group.

The Committee suggests, however, that there is a danger of overlapping services unless there is a clearly defined plan for coordination of vocational rehabilitation services with the Manpower Programs of the Department of Labor and the Office of Economic Opportunity. A beginning has been made in this direction in Region IV through such programs as the Concentrated Employment Program, CAMPS, ODC-JET, JOBS, INC., but the proliferation of programs and the duplication of effort still continue.

> THE COMMITTEE RECOMMENDS THAT THE GOVERNOR'S COUNCIL ON REHABILITATION STUDY EXISTING RELATIONSHIPS AMONG DVR, CBVH, THE STATE DEPARTMENT OF LABOR AND OTHER RELATED AGENCIES TO DEVELOP GUIDELINES FOR IMPROVING COMMUNICATION, COORDINATION AND JOINT PLANNING WHICH WILL ELIMINATE DUPLICATION OF SERVICES AND REDUNDANT PROGRAMS.

THE COMMITTEE PROPOSES THAT THE EXISTING STATE VOCATIONAL REHABILITATION AGENCIES ENGAGE IN AN ACTIVE CASEFINDING PROGRAM THROUGH COOPERATION WITH OTHER AGENCIES IN MULTI-PURPOSE COMMUNITY CENTERS.

Such centers have been demonstrated to be one of the more effective ways of utilizing services of various agencies without duplications and of developing communications between agencies.

When the vocational rehabilitation process is extended under the 1968 Vocational Rehabilitation Amendments to the socially and culturally disadvantaged, the profession is faced with a new dimension- the obligation to undertake changes in the social climate and in public attitudes on a much larger scale than heretofore. One of the key issues rehabilitation professionals now need to recognize is the fact that being poor does not make people identical in their needs, aspirations or values. Rehabilitation services must be flexible and imaginative if they are to accommodate these individual differences. In order to do so, however, our traditional concepts of personal adjustment training will need to be changed to accept these values. Prejudices and biases of counselors themselves first need modification. Important changes in professional attitudes and behavior are required. Participation of vocational rehabilitation counselors in multi-service centers where minority groups are well represented is one of the methods through which such changes can be accomplished. Involvement of industrial leaders and union personnel in the rehabilitation process has proven an effective educational method. "Sensitivity training" courses provided by the New York State Employment Service to employers enabling them to understand the problems and the potential of the disadvantaged are an example of such measures.

THE COMMITTEE RECOMMENDS THAT SENSITIVITY TRAINING SHOULD BE A PART OF THE CURRENT AND FUTURE EDUCATIONAL PROGRAMS FOR PROFESSIONAL PERSONNEL BOTH WITHIN AND OUTSIDE REHABILITATION CENTERS.

Utilization of indigenous aides is an important adjunct in the rehabilitation of such disadvantaged groups.

Special Problems - The Alcoholic

Although programs for helping the alcoholic are being expanded, DVR reports very few candidates for rehabilitation in this category. The primary reason appears to be the fact that no universally effective treatment for alcoholism has yet been developed. The non-medical, non-professional agencies such as Alcoholics Anonymous appear to be having the highest degree of success.

An intoxicated individual seeking help is ineligible for any of the five agencies serving alcoholics in Erie County. The eligibility requirements at the Buffalo State Hospital alcoholic rehabilitation unit require that the patient be without active psychotic disorder, have no serious criminal charge pending, have no history of felonies involving major crimes, not be intoxicated or in physical stress at the time of admission, and adhere to the rules governing the program. Such admission requirements exclude the majority from getting help. In Rochester the alcoholic program for Monroe County provides rehabilitation services for alcoholics who have been referred by the courts to the Monroe County Community Health Center Continued Care Unit. DVR has been involved in this program for the past six months and reports 15 of 79 men admitted to the Unit have been placed in gainful employment.

Such programs are to be commended but fail to go far enough. The Committee finds that the problem drinker needs to be identified and assisted before he breaks the law or enters the psychiatric ward.

The Community Welfare Council of Buffalo and Erie County has submitted proposals for the rehabilitation of alcoholics as a part of its programs for homeless men. The Region IV Committee endorses the following proposal for the establishment of a program for alcoholics in the two counties having the largest cities.[9]

A POSITION OF COORDINATOR OF ALCOHOLISM SERVICES SHOULD BE ESTABLISHED IN ERIE AND MONROE COUNTIES.

Inasmuch as various county agencies such as the Department of Social Services, the County Probation Department, Sheriff's Office, Penitentiary and Family Court are dealing with the problem of alcoholism in various ways, coordination of programs directed toward rehabilitation services is indicated. The State Rehabilitation Agency should be involved in the rehabilitation program and furnish counseling, vocational evaluation, training and placement.

PROGRAMS

The Aging

The number of persons 65 years and over in New York State is expected to increase from 1,859,000 in 1965 to 2,397,000 in 1985. In the state as a whole 10.1 percent of the population was 65 years or older according to the 1960 Census, but the proportion of aged in Region IV was higher- 11.5 percent. Among the specific disability groups discussed earlier, it should be noted that a majority of the blind are aged and that the incidence of deafness increases with age. Medical science has increased the life span but such progress is meaningless unless the later years yield opportunities for productivity, creative activity and self-esteem.

The majority of the poor in rural populations are 65 and over. A study, The Nature of Poverty in Chautaqua County,[10] made by the Western New York School Study Council shows that the great majority of the poor in that county are aged, and concludes:

> "As the descriptions of the aged poor indicate, there is much talent among this group. With ingenuity, these talents could be harnessed to assist those of the younger poor who can be economically productive (particularly mothers) through the manning of child care centers, nurseries and home extension services. The more able of the aged group could also minister to the needs of the less able within their own group."

THE COMMITTEE PROPOSES THAT SPECIALISTS IN PROVIDING VOCATIONAL REHABILITATION PROGRAMS FOR THE ELDERLY BE APPOINTED IN THE STATE REHABILITATION AGENCY.

Such specialists would cooperate with other agencies in the community now having programs for the aged, such as the Office for Aging, New York State Employment Service, State Education Department agencies, the Office of Economic Opportunity and community agencies in setting up programs.

Facilities and Workshops

In view of the fact that the Workshop and Facilities Planning Project of the Division of Vocational Rehabilitation has not yet made available to the Region IV Committee its special study of these agencies the report on this section must be regarded as incomplete. However, the following suggestions are based on the experiences of Committee members and findings which have emerged from the Cornell University Rehabilitation Research Institute Studies.

Since the probability of placement of workshop clients appears highest for those with 4 to 12 months of service, and placement rates decline with increasing tenure, the Committee recommends that

GREATER USE SHOULD BE MADE BY WORKSHOPS OF WORK-TRIAL PERIODS IN COMPETITIVE EMPLOYMENT AT APPROPRIATE STAGES IN THE CLIENT'S DEVELOPMENT.

WAGE AND HOUR REGULATIONS RELATING TO WAGES PAID TO WORKERS IN SHELTERED WORKSHOPS AND TO THE OVERHEAD TO BE APPLIED WHEN SUBMITTING BIDS SHOULD BE UNIFORMLY ENFORCED IN ALL SHOPS WHETHER THEY ARE OPERATED BY A PRIVATE AGENCY OR BY THE STATE OR FEDERAL GOVERNMENT IN A HOSPITAL OR OTHER INSTITUTION.

Although the exemption given to government facilities in these regards was rescinded in 1966, several states took exception to the change and enforcement has been delayed. Currently the Wage and Hour Division of the United States Department of Labor is awaiting work from the Attorney General as to how to proceed. It appears that past inequities may be corrected, but follow-up is in order to ensure that they are and that the law is carefully interpreted and consistently enforced.

EXISTING SPECIALIZED WORKSHOPS SHOULD BE ENCOURAGED TO BECOME COMPREHENSIVE WORKSHOPS SERVING ALL TYPES OF HANDICAPPED, AND COMPREHENSIVE WORKSHOPS NOW IN OPERATION SHOULD BE ENCOURAGED TO PROVIDE SPECIAL SERVICES FOR ALL SPECIAL DISABILITY GROUPS.

Programs should be made available to such generic or comprehensive workshops for training of staff in techniques required for special disability groups.

Elsewhere in this report the recommendation has been made for Community Advisory Committees. The Region IV Committee recommends that

ALL APPLICATIONS FOR WORKSHOP AND FACILITIES GRANTS SHOULD BE CONSIDERED IN CONJUNCTION WITH COMMUNITY ADVISORY BODIES.

Under the existing system, grants may not consistently reflect priorities in community needs. A local body, engaged in continuous review of such needs, is in an advantageous position to determine which facilities could best benefit the community through utilization of such grants.

Since it is recognized that certain individuals will never be able to attain the ability to engage in competitive employment and will require sheltered employment,

IT IS RECOMMENDED THAT STATE SUBSIDIES BE PROVIDED FOR THE MAINTENANCE OF EMPLOYMENT IN SHELTERED WORKSHOPS.

This should stimulate workshops to maintain steady employment. Some communities, because of the nature of the industrial complex, are in a better position to obtain contracts than others. It is recommended that wherever possible, workshops should share contracts or coordinate their contract procurement activities in the same fashion that knowledge of job information is pooled through the proposed JOB BANK. State subsidies should be provided for the development of long-term sheltered workshops for those persons who need to be maintained in such workshops and are unable to engage in competitive employment.

Re-evaluation of existing workshops is an immediate need. The purpose of the sheltered workshop should be mainly to train the individual for employment and secondarily to maintain those who cannot achieve minimum productivity in employment. It is therefore recommended

THAT BY JOINT ACTION THROUGH THE DIVISION OF VOCATIONAL REHABILITATION AND THE SMALL BUSINESS ADMINISTRATION, SEPARATE, PROFIT-MAKING CORPORATIONS SHOULD BE SET UP AND, AT THE OUTSET, SUBSIDIZED FOR GROUPS OF HANDICAPPED INDIVIDUALS WHO CANNOT FIND EMPLOYMENT IN COMPETITIVE INDUSTRY BUT WHOSE PRODUCTIVITY IS AT OR ABOVE STANDARDS FOR MINIMUM WAGE RATE OF PAY.

It is expected that these corporations will become self-supporting and provide employment for other handicapped.

The Rural Disadvantaged

The rural disadvantaged, though having many problems in common with the urban poor, such as lack of education, low and sporadic income and substandard housing, will be even more difficult to reach for purposes of vocational rehabilitation. In the study, The Nature of Poverty in Chautauqua County[10] prepared by the Western New York School Study Council, it is pointed out that the "overwhelming number of poor in the county are white. They typically do not live in ghettos but are dispersed among the total population. Many live in the country, but are not farmers. Many are aged." (This study of the rural poor does not include the migratory workers who are discussed later in this report.) What is significant in the study is evidence that poverty not only breeds illness but creates waste and attrition of human resources. The rate of school dropouts is extremely high, and in families where at least one parent has a high school education, the children are failing to reach an educational level as high as their parents. Wives in the group were found to have generally more education than their husbands, but a lower participation rate in the labor market than wives in the control group. The elderly, comprising 60 percent of the total group, showed a rich potential for social usefulness and a high degree of motivation which is not being utilized.

THE COMMITTEE RECOMMENDS THAT INTAKE POINTS, PROVIDING NOT ONLY INFORMATION, BUT ALSO ACCESS AND RAPID REFERRAL TO SERVICE CENTERS BE ESTABLISHED IN SHOPPING CENTERS IN THE SMALL COMMUNITIES SERVING THE RURAL POPULATION.

Such a service would prevent overlapping of community services, provide coordination of services and eliminate duplication of records. From such intake points clients could be referred to county rehabilitation centers for vocational evaluation, personal adjustment and vocational training, and other services.

Though the decline of agriculture in the job market is rapidly accelerating, New York State had in 1967 approximately 16,900 interstate farm workers. An additional 12,000 seasonal agricultural workers were recruited from the towns and cities through day-haul operations. These workers have no unemployment insurance or Workmen's Compensation coverage. They are vulnerable to unpredictable layoffs due to wind, weather and plant pestilence. Among them are a few skilled farm workers capable of arranging their work patterns in a manner to earn a fairly acceptable annual wage. But far more typical are those displaced from other occupations or unable to find stable employment elsewhere. Many are sharecroppers displaced by technological changes; others are the victims of industrial unemployment, personal catastrophe, physical handicap or educational disability.

The Migrant Ministry of the Council of Churches[11] identifies the major problems of the migrant worker group as irregularity of employment and low family income, disenfranchisement, exception from social legislation, discrimination, low educational attainment, and cultural deprivation and isolation. The New York State Joint Legislative Committee on Migrant Labor reports that "migrant laborers as well as other agricultural workers in this State are a deprived minority, who reap very few benefits from the crops they harvest."

On the positive side, the State Health Department has stepped up its program during the past year of improving health and housing standards for the migrant agricultural worker. Permits were issued to 841 labor camps.

The Committee on Education and Labor of the 90th Congress, in commenting on the 1967 Amendments to the Vocational Rehabilitation Act, refers to

> "the serious plight of thousands of migrant workers who represent a widely known segment of our population who are never furnished the same public services as other citizens. The prevalence of disability conditions, some having their origin in chronic illness long neglected, and others arising from accidents on the job, the highway or elsewhere, calls for special attention and action.
>
> The estimated migrant population in the United States including families is 2 million. At least two percent or 40,000 persons would be eligible and feasible for vocational rehabilitation services. Of this number, it is estimated that about 3,000 to 5,000 people would seek or be referred for services each year."

Since the 1967 Amendments to the Vocational Rehabilitation Act provided for pilot project grant for migratory workers, and it is recognized that Wayne County has the highest percentage of migrant workers in the Region,

IT IS THEREFORE RECOMMENDED THAT THE STATE VOCATIONAL REHABILITATION AGENCY SHOULD ESTABLISH A PILOT PROJECT FOR RESIDENT MIGRANT WORKERS AND MOBILE MIGRANT WORKERS IN WAYNE COUNTY TO DETERMINE THE BEST APPROACH OF PROVIDING VOCATIONAL REHABILITATION SERVICES TO MEET THE NEEDS OF BOTH POPULATIONS.

For the mobile migrant workers it is suggested that a communication system be developed with the State to which the mobile worker returns, so as to have ongoing follow-up with respect to vocational rehabilitation needs.

Social Security and Vocational Rehabilitation

The amendments to the Social Security Act which have extended eligibility to the temporarily disabled, and which delegated the responsibility for determination of disability to the state rehabilitation agencies have provided access to vocational rehabilitation to many more disabled. It will be noted from the Task Force Report on the Blind that OASI is the largest single referral source in the 50 new referrals analyzed. Since more than 75,000 OASI beneficiaries in the United States have returned to work and left the benefit rolls since the program began, many without the benefit of professional rehabilitation services, it seems clear that there is a good potential for rehabilitation among this group. Recent pilot studies conducted under joint VRS and Social Security sponsorship seem to indicate the need for (1) earlier referral of the disability applicant to the rehabilitation agency, (2) earlier detection of good rehabilitation potential through the combined efforts of medical and allied community resources, (3) greater stress on personal adjustment training and counseling to overcome the applicant's tendency to believe that he cannot perform any work other than his former job, and (4) use of more comprehensive and effective screening procedures and more closely coordinated services. A VRA pilot study recently demonstrated that persons with several disabilities can be rehabilitated at the same rate of success as other handicapped groups through use of such techniques.[12]

To further effectuate the delivery of services within urban communities, it is recommended that

ADDITIONAL FUNDS SHOULD BE PROVIDED TO THE STATE REHABILITATION AGENCY OR OFFICE SO THAT ADDITIONAL VOCATIONAL REHABILITATION COUNSELORS CAN BE ASSIGNED TO WORK IN MULTI-PURPOSE COMMUNITY REHABILITATION CENTERS.

In order that state and voluntary rehabilitation agencies may have the benefit of community planning and a greater insight into grass roots attitudes and needs, it is proposed that

EACH COUNTY SHALL ESTABLISH A STRONG COMMUNITY ADVISORY BODY COMPOSED OF LAY AND PROFESSIONAL PERSONS AND FULLY REPRESENTATIVE OF ALL SEGMENTS OF THE POPULATION.

The district and county planning groups of the Advisory Committee for Statewide Planning for Vocational Rehabilitation have a composition appropriate to suggest that these committees continue to function on a permanent basis.

In order to encourage the continued development of voluntary agencies and to provide additional services to smaller communities not in a financial position to offer the full spectrum of services, the Committee recommends that

REGIONAL VOCATIONAL REHABILITATION FACILITIES SHOULD BE DEVELOPED.

It is suggested that such regional facilities might be under either private or public auspices. Within the Region there are four vocational rehabilitation facilities which could be encouraged to provide expanded programs. The functions of such regional centers, in addition to the full spectrum of vocational rehabilitation services, should include professional consultation and guidance to local centers, and exchange of services between agencies. In addition, such regional centers should provide transportation services and residences. The regional centers should provide services for the multiply handicapped, and develop itinerant teams and/or rehabmobiles to extend the program to more remote areas. Regional rehabilitation facilities should conform to standards established by the Commission on Accreditation of Rehabilitation Facilities. Professional staff should be amply supplemented by aides and clerks, and a continuing education program for staff should be provided at all levels. Clients should be regarded as logical candidates for staff positions where suitable.

IT IS PROPOSED THAT THE CHAUTAUQUA, CATTARAUGUS, ALLEGANY AREAS UTILIZE EXISTING AND IMPROVED REHABILITATION FACILITIES IN EACH OF THESE THREE COUNTIES, AND COORDINATING SERVICES IN AN APPROPRIATE SEQUENCE FOR INDIVIDUAL CLIENTS.

For example, a community rehabilitation center at the Women's Christian Association Hospital in Jamestown could provide medical evaluation services, a community rehabilitation center at St. Bonaventure University in Olean could provide testing and assessment of vocational potential services. A community rehabilitation center at Wellsville could provide vocational training services. As potential clients for vocational rehabilitation service come forward and are identified, possible need for the growth of existing facilities must be recognized.

The Committee agreed that wherever feasible, services should be brought to the applicant, and therefore, it wishes to emphasize the necessity of decentralization of services. We recommend that

LOCAL REHABILITATION FACILITIES BE ESTABLISHED IN EACH COUNTY OR COMMUNITY.

Such local facilities would provide workshop activities, both transient and terminal, development of employment opportunities in both the public and private sectors, and other services to the extent the community is able to support them. In some instances, such local facilities could be satellites of regional facilities until such time as they are able to provide a complete program. They should be encouraged to work constantly toward local autonomy and to upgrade and expand staff through utilization of training programs at the regional centers and elsewhere. In suggesting the establishment of county rehabilitation centers or satellites, the Committee does not intend to imply rigidity in this respect. The overriding impression from the study is the need for regional planning as relevant to the client and services as possible but with a geographical base large enough to warrant proper facilities and supervision. Where a county is large enough, it may be desirable to limit the planning region to that county.

Disabled Youth

A sub-committee of the District 8 Advisory Committee has made a study of the needs of disabled youth. On the basis of this study the Region IV Committee makes the following recommendations:

> THAT VOLUNTARY AGENCIES SERVING SPECIAL GROUPS, SUCH AS THE BLIND, THE DEAF, AND THE MENTALLY RETARDED SHOULD OFFER CONSULTATION SERVICES TO PUBLIC AND PRIVATE SCHOOLS HAVING SUCH HANDICAPPED STUDENTS ENROLLED.
>
> THAT THE STATE VOCATIONAL REHABILITATION AGENCY PROVIDE PERSONNEL WHO WOULD PERFORM MORE ENTENSIVE LIAISON SERVICE WITH THE SCHOOL NURSE AND SCHOOL GUIDANCE PERSONNEL TO ENSURE REFERRALS OF THOSE NEEDING SPECIAL VOCATIONAL REHABILITATION SERVICES.
>
> THAT THE VOCATIONAL REHABILITATION AGENCY PROVIDE EDUCATIONAL SERVICES INCLUDING SPEAKERS FOR PTA GROUPS AND GUIDANCE COUNSELOR MEETINGS TO INFORM TEACHERS, PARENTS, AND SCHOOL PERSONNEL OF AVAILABLE SERVICES.

The Tompkins County Committee reports that its findings indicate that special education in the public schools does not prepare the handicapped child for vocational rehabilitation. The Region IV Committee therefore recommends that

> A JOINT STATE COMMITTEE OF THE DIVISION OF VOCATIONAL REHABILITATION AND THE STATE EDUCATION DEPARTMENT SHOULD BE FORMED TO DEVISE A CURRICULUM OUTLINE SEQUENCE FOR THE HANDICAPPED CHILD.
>
> Such a curriculum sequence should begin at the pre-school level and continue upward, giving the handicapped child an effective education so that vocational rehabilitation becomes a part of his continuum in preparation for constructive living in the community. District 7 has prepared a set of guidelines for the development of an integrated and shared vocational rehabilitation plan which suggests coordination of existing educational facilities.
>
> AS IT RELATES TO THE MORE SEVERELY HANDICAPPED CHILD, THE DEFINITION OF VOCATIONAL REHABILITATION SHOULD BE RE-EXAMINED.
>
> This is recommended on a statewide level, preferable under the joint sponsorship of the Vocational Rehabilitation Agency and the Department of Mental Hygiene. Within the present definition of vocational rehabilitation, many of the handicapped persons herein referred to as "hard core" are ineligible for vocational rehabilitation. The 1965 Vocational Rehabilitation Act gave token recognition to this point by establishing the "rehabilitation through potential programs". Expansion of such programs is recommended.

Workmen's Compensation

The Second Injury Clause of the Workmen's Compensation Law designed to encourage employers to hire the handicapped by offering limited protection from claims for injury by those handicapped knowingly hired has not served sufficiently to perform its purpose.

> THEREFORE THE COMMITTEE RECOMMENDS THE FOLLOWING CHANGES IN THE WORKMEN'S COMPENSATION LAW:
>
> (1) IN LIEU OF THE PRESENT REQUIREMENT THAT THE EMPLOYER HAVE KNOWLEDGE OF A PRIOR HANDICAP, REQUIRE ONLY THAT THE EMPLOYER OBTAIN AN EXAMINATION OF THE EMPLOYEEE OR NEW JOB APPLICANT AND CERTIFICATION BY A PHYSICIAN THAT THE EXAMINATION DISCLOSES A PERMANENT PHYSICAL IMPAIRMENT.
> (2) LIMITATION OF THE EMPLOYER'S LIABILITY TO 26 WEEKS INSTEAD OF THE CURRENT 104 WEEKS.
>
> These recommendations are discussed in more detail in the Rochester report, An Approach to a Problem in Compensation and Rehabilitation.[13]

FURTHER, THE COMMITTEE RECOMMENDS THAT COVERAGE UNDER THE WORKMEN'S COMPENSATION LAW BE EXTENDED TO AGRICULTURAL WORKERS, THUS PROVIDING AN AVENUE TO VOCATIONAL REHABILITATION SERVICES.

State Employment Service

The State Employment Service and the Division of Vocational Rehabilitation have an agreement whereby clients of the Division of Vocational Rehabilitation ready for employment are referred to the Employment Service for placement. The arrangement has had varying degrees of success in different localities. Since both the Division of Vocational Rehabilitation and the New York State Employment Service exercise a placement function, the Employment Service personnel have sometimes erroneously assumed that the Division of Vocational Rehabilitation clients referred are those with the lowest employment potential and are referred only after the Division of Vocational Rehabilitation counselor has exhausted the possibilities for placement. This fact, combined with the emphasis on placement figures in the Employment Service, has had a discouraging effect on counselors assigned to Special Placement (i.e., placement of the handicapped). Special Placement Employment Service counselors devote a high proportion of time to placement efforts for the "closed" cases of the Division of Vocational Rehabilitation, and there is little exchange of information between the Division of Vocational Rehabilitation and the New York State Employment Service on such cases, which have been "closed rehabilitated" after 30 days on the job. In cases such as the emotionally disturbed, where turnover is high, this practice places a heavy burden of rehabilitation counseling on the Employment counselor. Some Special Placement counselors in the Employment Service are assigned to this function only on a part-time basis. Medical data on the Division of Vocational Rehabilitation "closed" cases is hard to come by, and the time lag in receiving such data compounds the problem of placement.

> THE COMMITTEE RECOMMENDS THAT A MORE REALISTIC MEASURE OF SUCCESS BE SUBSTITUTED FOR THE PRESENT EMPHASIS ON NUMBERS OF PLACEMENTS.
>
> Recent concentration on the placement of the disadvantaged by the Employment Service and the recognition that the placement ratio for this group is likely to be lower than the general average will hopefully tend to diminish the emphasis on numbers of placements as a measure of counselor achievement. If the budgets in the Employment Service continue to be geared to numbers of placements, it is suggested that double credits be given for the placement of "difficult" cases, and that recognition be given for other services to this group.
>
> STUDIES SHOULD BE MADE TO ESTABLISH A BETTER CRITERION THAN CLOSURE IN DVR AS A MEASURE OF EFFECTIVE REHABILITATION, AND THAT THIS CRITERION BE APPLIED TO PRIVATE AGENCIES AS WELL, PARTICULARLY IN THOSE CASES WHERE THE JUDGMENT AS TO THE SUCCESS OF A GRANT PROJECT IS BASED ON THE NUMBER OF PERSONS REHABILITATED ACCORDING TO DVR STANDARDS.
>
> ADDITIONAL COUNSELORS IN THE EMPLOYMENT SERVICE SHOULD BE ASSIGNED ON A FULL-TIME BASIS TO SPECIAL PLACEMENT AND RECEIVE IN-SERVICE TRAINING WITH THE STATE REHABILITATION AGENCY.
>
> COMPLETE JOB INFORMATION SHOULD BE SHARED BY THE EMPLOYMENT SERVICE WITH THE STATE REHABILITATION AGENCY AND WITH VOLUNTARY REHABILITATION AGENCIES THROUGH A COMPUTERIZED JOB BANK.
>
> JOINT CASE RECORDS SHOULD BE MAINTAINED BY EMPLOYMENT SERVICE COUNSELORS AND DVR COUNSELORS WHERE FEASIBLE, ESPECIALLY IN MULTI-SERVICE COMMUNITY CENTERS.
>
> A common fact sheet including the information required by both agencies would minimize paper work operations and the lengthy and duplicate intake interviews which are discouraging to the client.

The Committee finds that the proliferation of manpower programs for the disadvantaged under the New York State Employment Service, each having different eligibility requirements and affording different methods of reimbursement to employers and applicants, serves to create barriers instead of access to opportunity for those whom they are designed to serve. Fortunately, the New York State Senate Labor and Industry Committee has attacked this problem, and the following is a quotation from their report of July 18, 1968:

> "A multiplicity of federal programs rarely building upon existing legislation has created a haphazard approach which is neither adequate nor effective. There is no coherent federal manpower policy nor a single comprehensive federal agency coordinating manpower programs ... Our manpower programs are oriented toward federal government expenditure, program design and control ... these programs- to a large extent good programs, which have had some success- involve private enterprise in only a limited manner ... Private enterprise has already begun to awaken to the nation's

> needs ... Private response to federal requests for partnership may be expected to be enthusiastic. But, if private enterprise is to contribute to the greatest extent, government financial assistance will be necessary ...
>
> "An urgent need for a state manpower goal was put forth by the (Senate) Committee as the first step in resolving the state's manpower problems. The Committee suggested a Guaranteed Manpower Training Act as a means for providing this goal. The Act would in effect guarantee job training, skill upgrading, vocational education, and related means of occupation advancement to all workers who could reasonably benefit. The program envisioned establishing a definite series of priorities based on an assessment of the manpower training needs of the state.
>
> "To fulfill the goals presented by such a guaranteed job training program, the Committee suggested an umbrella agency at the state level to coordinate all programs to produce innovations in community manpower training. The Committee further recommended an expansion of manpower training programs particularly those of the on-the-job training variety to levels approaching need. Although the Committee regards the federal government as the chief source of manpower funds, it suggested a well-measured expansion of the state's Manpower Development Program. An increase of $40 million in the State Manpower Training Program was deemed vital to a meaningful attack on hard-core unemployment.
>
> "To effectively bring manpower services to the disadvantaged, the Committee proposed a Search and Employ Program to mobilize the resources of a variety of agencies in seeking new ways to bring services to the ghetto. A Model Manpower Planning Grant program was suggested to provide for innovative manpower development planning at the community level.
>
> "A new role for the State Employment Service was envisioned by Committee proposals for expanding its functions to achieve a central labor exchange . . .
>
> "It is the Committee's earnest belief that the chief problem in unemployment is bridging the skill gap created by a technologically advancing economy. New attitudes, new training methods, and new commitment by government to erasing, not merely alleviating, hard-core unemployment are the necessary ingredients. . ." 14

If the Senate Committee's recommendations are enacted by the 1969 Legislature, the range of on-the-job training possibilities for the Division of Vocational Rehabilitation clients will be greatly expanded, and such legislation, if passed, will call for close liaison between the State Rehabilitation Agency and the State Employment Service to avoid overlapping of the on-the-job and other training programs. It becomes, therefore, more imperative that one of the functions of the proposed Placement Coordinator in the State Rehabilitation Agency will be planning for its clients' participation in all types of training programs administered by the State Employment Service.

INTERAGENCY COORDINATION OF SERVICE PROGRAMS

Education

Representatives of the District Boards of Cooperative Education, local boards of education, privately endowed colleges, community colleges, the State University, its colleges and Urban Extension Centers have served as members of the District IV Advisory Committee. The Committee found that while there are many vocational education facilities as well as higher educational facilities in the Region, there is need for better dissemination of information about such training facilities and the courses they offer. A directory of training facilities approved for the Manpower Development Training Act has been circulated to State Employment Services, and might serve as a basis for a directory to be circulated to rehabilitation personnel.

The Committee also found that while vocational training is readily available for recent high school graduates, there is an inadequacy of vocational training for adult high school drop-outs seeking to make up educational deficits and learn a trade. The State University Extension program at Wellsville is one of the few such programs in the area and it is seeking to expand this program with emphasis on providing special facilities for handicapped students.

> THE COMMITTEE RECOMMENDS THAT THIS PROGRAM BE ENCOURAGED THROUGH THE PROVISION OF A CONSTRUCTION GRANT TO THE STATE UNIVERSITY OF NEW YORK AT WELLSVILLE AND ALFRED TO PROVIDE A CONTINUUM OF SERVICES.

The Committee also finds there is need for closer liaison between vocational educational facilities and private industry so that vocational training can be better related to the changing technology and the job market.

> THEREFORE IT IS RECOMMENDED THAT VOCATIONAL TRAINING SCHOOLS BE ENCOURAGED TO DEVELOP ADVISORY BOARDS FROM PRIVATE INDUSTRY FOR THE PURPOSE OF CURRICULUM DEVELOPMENT AND TECHNICAL ASSISTANCE.

Public Health

Regional and county health commissioners have been members of the Region IV Advisory Committee and have contributed various suggestions relative to the public health aspects of this report as have representatives of voluntary and other State and local agencies. All of the members of the Interdepartmental Health and Hospital Council were also members of the Region IV Advisory Committee.

One of the recurrent subjects of discussion in Committee meetings was the structure of the Primary and Secondary Rehabilitation Centers. The Committee recognizes the need for more physical and medical rehabilitation services, and the value of coordination between the Primary Centers that are attached to a major teaching facility, and the Secondary Centers. In practice, however, there has been very little coordination between Primary and Secondary Centers in the Region. The Primary Centers in Rochester and Buffalo offer vocational evaluation and training through hospital-based activities. The Secondary Centers do not have such services in all cases. There was some doubt expressed by members of the Committee as to whether a hospital is the logical site for the development of a vocational rehabilitation program, having as it does in the minds of the community an illness-oriented image.

> THE REGION IV COMMITTEE THEREFORE RECOMMENDS THAT THE FUNCTION OF THE PRIMARY AND SECONDARY REHABILITATION CENTERS BE RE-EVALUATED.
>
> It is suggested that the emphasis of the Primary and Secondary Centers should be upon physical and medical rehabilitation and that Community Vocational Rehabilitation Facilities be located near such centers and provide continuing vocational services. A plan for the geographical distribution of such groups of facilities is outlined in the District 6 report. This plan suggests additional physical and medical rehabilitation centers we well as additional vocational rehabilitation centers. This recommendation should not be construed as restricting these from maintaining the vocational services they now provide.

District 7 has referred in its report to the "Organizational Study of State Rehabilitation Agencies" issued by the Office of the Secretary to the Governor (October 1960) which strongly encouraged state and local governments to refer their patients or clients to the community facilities.

> THEREFORE THE REGION IV COMMITTEE RECOMMENDS A CONTINUED EMPHASIS ON THE DEVELOPMENT OF COUNTY HEALTH DEPARTMENTS.
>
> However, there should be a re-evaluation of the role of the county health department as it relates to direct patient services. Home health services as authorized by Medicare should be encouraged to evolve out of non-official community agencies. Likewise, the network of State Orthopedic Clinics should gradually be phased out as community rehabilitation centers for evaluation and treatment are locally developed. It is understood that this will be a transitional process.

ADMINISTRATIVE ASPECTS

Public Relations

The Committee found a need for an adequate public relations program designed to educate not only the public, in an effort to change stereotyped attitudes toward the handicapped, but also first-line supervisors in industry, and the professional staff of agencies as well.

In its exploration of the barriers to effective rehabilitation, the District 8 Committee found that attitudes were a significant factor. Attitudes on the part of both public and private agency personnel often tend to discourage the client from seeking help. Most agency location, hours, and scheduling practices are based on convenience for the staff rather than the client. Criteria for eligibility tend to be based on a prejudgment or stereotype, such as "lack of motivation." Agency staff has a tendency to determine "what is best for the client" and reject those clients not susceptible to fitting into the agency pattern. Emphasis on eligibility factors, rather than need, has led to the attitude that a new client is a "headache" for agency staff rather than a "valued customer" for their services.

Employers' attitudes toward hiring the handicapped were found to be ambivalent, often because of inconsistencies in attitudes of placement personnel. Although much publicity has been given to the thesis that handicapped workers are valuable workers having assets such as lower absentee records, this approach to employers is not always realistic. Public attitudes toward the client were found to be that disabled individuals are "sick" people and should be so regarded and treated.

THE COMMITTEE THEREFORE RECOMMENDS THAT CONTINUOUS IN-SERVICE TRAINING OF AGENCY PERSONNEL BE CARRIED ON AND THAT A MORE EXTENSIVE PUBLIC EDUCATION PROGRAM REGARDING THE HIRING OF HANDICAPPED WORKERS BE INSTITUTED.

Administrative Aspects of the State Vocational Rehabilitation Agencies

EACH OF THE FOUR DISTRICTS IN REGION IV ARRIVED SEPARATELY AT THE CONCLUSION THAT THERE SHOULD BE A CONSOLIDATION OF STATE VOCATIONAL REHABILITATION AGENCIES.

Vocational services are now being rendered by the Division of Vocational Rehabilitation, the Commission for the Blind and Visually Handicapped Handicapped, and the Workmen's Compensation Board under the "R" program. The rationale for this separation of services is not well defined. The Commission for the Blind preceded the Division of Vocational Rehabilitation historically, but the Committee finds that this is not a sufficient reason for continuing two agencies, both serving the visually handicapped. Furthermore it appears that many severely visually handicapped among DVR clients and among patients of private physicians are not being referred to CBVH partly because of the stigma attached to the label of blindness. It is suggested that the combination of services to all handicapped under one agency would tend to remove this stigma, and the State Rehabilitation Agency could then concentrate on providing adequate specialized services to those handicapped in this category.

It has also been observed elsewhere in this report that the separation of special disability categories into their own workshops tends to perpetuate isolation and dependency, and that integration of various disability categories would tend to place more emphasis on the temporary nature of the workshop experience. The movement of other clientele from the workshop setting into competitive employment presents a motivating factor to the blind to move out into the community, and to participate to the fullest possible extent in social and work situations.

The lack of manpower sufficiently trained to deliver adequate services to all who need them has been a major subject of discussion within the Committee. It has been suggested that all vocational rehabilitation counselors have master's degrees by 1975. Although recognizing the importance of constant upgrading of personnel through continuing education, the Committee finds that the establishment of such a requirement would not necessarily be a total solution to the manpower problem. Due recognition should be given to the value of experience, personality assets, and training in other fields. Furthermore the output of colleges and universities will not be sufficient to produce personnel with the required degrees in the health, mental health, rehabilitation, and personnel fields within the next decade.

THE COMMITTEE THEREFORE RECOMMENDS THAT STUDIES BE UNDERTAKEN TO DEVELOP EQUIVALENCY RATINGS SO THAT PEOPLE QUALIFIED BY EXPERIENCE AND OTHER FACTORS CAN BE EMPLOYED.

These people must be considered satisfactory to meet the requirements of grant and other aid programs.

THE COMMITTEE RECOMMENDS THAT THE DEVELOPMENT OF TRAINING PROGRAMS TO PRODUCE NEW TYPES OF PARA-MEDICAL AND BEHAVIORAL SCIENCE PERSONNEL SHOULD BE AUTHORIZED.

The health-care manpower survey of 1967 conducted by the Health Organization of Western New York, though of tremendous value as an index of needs, does not point to any particular solution of these problems.

THE COMMITTEE RECOMMENDS THAT THE STATE DEPARTMENT OF EDUCATION AND THE DEPARTMENT OF CIVIL SERVICE DETERMINE THE FEASIBILITY OF CHANGES IN THE PATTERNS OF WORK DISTRIBUTION, JOB DESCRIPTION MODIFICATION AT THE CIVIL SERVICE LEVEL, THE APPROPRIATENESS OF THE CAREER-LADDER CONCEPT IN STATE AGENCIES, AND OTHER NEW APPROACHES TO THIS PROBLEM OF FINDING THE RIGHT PEOPLE FOR THE RIGHT JOB AT THE RIGHT TIME.

The medical specialists most intimately concerned with vocational rehabilitation have traditionally been in the field of physical medicine and are usually board-certified psychiatrists. This specialty, at a time when its services are going to be in much greater demand, is apparently one of the slowest growing in medicine. The Commission on Education in Physical Medicine and Rehabilitation has established the need for 4,000 physiatrists by 1970.* Its research staff indicates that there will be only 700 board-certified physiatrists by that time. Therefore recognizing that the supply of certified physiatrists will not be adequate to meet the needs of the next decade,

IT IS RECOMMENDED THAT PILOT STUDIES OF LOCAL COMMUNITIES BE CONDUCTED AT REHABILITATION CENTERS IN NEW YORK STATE TO DETERMINE BETTER UTILIZATION OF MEDICAL SPECIALISTS SUCH AS ORTHOPEDISTS AND NEURO-SURGEONS, INTERNISTS, AND OTHERS CURRENTLY PRACTICING IN THOSE COMMUNITIES WHO WILL BE INVOLVED IN THE MEDICAL EVALUATION OF VOCATIONAL REHABILITATION CLIENTS.

In response to the developing recognition of the manpower crisis in the field of physical, mental and vocational rehabilitation, and with an awareness of the growing interest in concepts of generic as opposed to specialized training,

THE COMMITTEE RECOMMENDS THAT THE BOARD OF TRUSTEES OF THE STATE UNIVERSITY OF NEW YORK, IN CONJUNCTION WITH THE STATE UNIVERSITY AND COMMUNITY COLLEGE NETWORK, DEVELOP TRAINING PROGRAMS TO DEVELOP NEW TYPES OF REHABILITATION PERSONNEL. THESE TRAINING PROGRAMS, FROM THE SHORT TERM AIDE LEVEL THROUGH DOCTORAL PROGRAMS, SHOULD INCORPORATE THE OPEN-END CAREER LADDER PHILOSOPHY.

As examples, the following categories are suggested: (1) Rehabilitation Aide programs of no more than six months duration with exposure to a core curriculum at State University of New York, and clinical experience in nursing, physical therapy, social casework, or other. The program is seen as short-term, leading to a job with some element of status, and as a means of recruitment. (2) Associate degree programs in community aide training leading to certificates and geared to various openings in the rehabilitation field such as social work aide, psychiatric aide, physical therapy and occupational therapy aides or others. (3) Baccalaureate degrees with generic training in the various helping professions with strong emphasis on the social sciences, psychology, and social work and rehabilitation techniques. (4) Master's degree programs in administration, clinical practice and education and research. (5) Professional level programs in othotics, prosthetics and allied health fields. (6) Physician assistants. (7) Electronic and other techicians. (8) Expansion of the top level to be included: in addition to M.D.'s and Ph.D.'s, a designation of Doctor of Rehabilitation Services, geared to administrative posts.

Confronted by studies which indicate that only an estimated 9% of the population who need vocational rehabilitation are currently being served, and with an estimated shortage of 60,000 vocational counselors

IT IS RECOMMENDED THAT THE POSITION OF "PLACEMENT COORDINATOR" BE ESTABLISHED IN THE STATE REHABILITATION AGENCY. THESE INDIVIDUALS WOULD PERFORM THE FUNCTION OF PLACEMENT, DEVELOP JOB MARKET INFORMATION AND SERVE AS LIAISON BETWEEN COUNSELOR, EMPLOYER, NYSES, AND THE PRIVATE AGENCY PLACEMENT PERSONNEL.

It is strongly recommended that job requirements for the coordinator do not include traditional degree requirements, but be based on experience, communicative skills, a knowledge of the community and job market and personality factors.

*Paul M. Ellwood, "Can We Afford So Many Rehabilitation Professions?" Journal of Rehabilitation, May-June, 1968.

THE COMMITTEE FURTHER RECOMMENDS THE DEVELOPMENT OF INDIGENOUS LEADERSHIP BY ALL AGENCIES.

It has been demonstrated that one of the most effective methods of reaching out to the hard-core unemployed is through the use of community aides who are members of the inner-city population. By the same token, handicapped individuals who have benefitted by the rehabilitation process should be utilized in reaching out to and motivating other disabled individuals. Elderly people for whom no placement opportunities can be developed in competitive employment can function effectively as home-visitors to the elderly, and in supplementing aspects of the homebound program. Thus, the term "indigenous" is used in its broadest application.

With reference to administrative locations of the State Vocational Rehabilitation Agency, the Committee finds that the present system of allocating itinerant personnel to rehabilitation services in the more remote and rural communities is not satisfactory.

IT IS RECOMMENDED THAT THE STATE REHABILITATION AGENCY ESTABLISH LOCAL OFFICES ALONG THE SAME STRUCTURAL LINES AS NOW UTILIZED BY THE STATE EMPLOYMENT SERVICE.

A Vocational Rehabilitation supervisor should be stationed in each county, or in each community of 100,000 or more with several offices in urban centers. These supervisors should be residents of the community in a position to understand and relate to community needs and community problems. Whereas it is suggested that the Community Vocational Rehabilitation Centers may be supported by county and voluntary funds, the state representative would have jurisdication over the ultilization of state funds and serve as a liaison officer with Regional and Community Rehabilitation Centers providing special services. Such a supervisor would also assist in the interchange of services between communities.

The Committee found that not all agencies are efficiently using staff, either professional or clerical. Delays in data collection, particularly diagnostic data, duplication of data, and delays in determination of acceptance and eligibility were found to be prevalent in both private and state agencies. The following recommendations are proposed to correct these conditions:

TO EXPEDITE EXAMINATION REPORTS THE DIVISION OF VOCATIONAL REHABILITATION AND LARGE REHABILITATION FACILITIES SHOULD EMPLOY THE SERVICES OF A PHYSICIAN TO PROCESS GENERAL MEDICAL EXAMINATIONS, AND THE DIVISION OF VOCATIONAL REHABILITATION SHOULD EMPLOY PSYCHOLOGISTS FOR CONSULTATION AND EXAMINATIONS.

IT IS RECOMMENDED THAT A UNIFORM DATA SHEET FOR INTAKE INTERVIEWS BE DEVELOPED FOR USE BY PUBLIC AND PRIVATE AGENCIES, AND THAT A UNIFORM MEDICAL INFORMATION SHEET ALSO BE DEVELOPED.

In the case of data collection, it was found that often more material is collected than is necessary. There is duplication of data collection when clients are referred from one agency to another.

In order to avoid delays in the delivery of services it is recommended:

THAT THE CONCEPT OF PRESUMPTIVE ELIGIBILITY BE ESTABLISHED BY DVR.

Certain types of disabled clients, such as those referred from a school for the deaf, a state mental hospital, or an amputee, can be presumed eligible for vocational rehabilitation services before complete medical data is received so that services can be initiated prior to receipt of medical reports without a long waiting period.

THE COMMITTEE RECOMMENDS THAT AN ONGOING CENSUS DATA COLLECTION ON THE HANDICAPPED BE INCORPORATED INTO THE FEDERAL CENSUS SYSTEM.

The Committee found, in its efforts to collect information on the prevalence and incidence of disabilities, that despite the circulation of numerous questionnaires from various sources, no reliable statistics were available.

Experience has shown that the district office with its budgetary limitations gives preference to those individuals who can be rehabilitated into employment within 26 weeks, and sometimes is compelled by such limitations to overlook the needs of the handicapped individuals who require more long-range intensive procedures. In statewide budgeting for vocational rehabilitation there should be a separation of funds and statistics for those person requiring long-term vocational rehabilitation from these persons requiring less than 26 weeks.

The measure of a rehabilitation counselor's performance in the state rehabilitation agencies has been the number of cases "closed rehabilitated." Such a measure inevitably discourages the acceptability of the "hard" cases, and tends to emphasize the number rather than the quality of services.

> IT IS THEREFORE RECOMMENDED THAT COMPLEX CASES SUCH AS MULTIPLY HANDICAPPED AND DISADVANTAGED BE GIVEN A WEIGHTED VALUE IN THE STATISTICAL REPORTING OF THE STATE REHABILITATION AGENCIES AND PRIVATE AGENCIES, PARTICULARLY IN REPORTS JUSTIFYING CONTINUATION OF GRANT SURRPORT.

The Committee wishes to pay tribute to great contributions and pioneering work done in the development of vocational rehabilitation by certain special groups, particularly those representing the blind, the deaf and the mentally retarded. Nevertheless the Committee suggests that special vocational rehabilitation agencies for special disability groups are no longer feasible and recommends that

> THE PHILOSOPHICAL CONCEPT OF INTEGRATION OF CATEGORICAL SERVICES FOR VOCATIONAL REHABILITATION BE ENCOURAGED IN THE EXPANSION OF EXISTING AGENCIES AND IN THE ESTABLISHMENT OF NEW AGENCIES, AND THAT EQUALLY IMPORTANT IS THE PROVISION OF SPECIALIZED SERVICES FOR SPECIAL DISABILITIES WITHIN THE OMNIBUS AGENCIES. ADEQUATE PROVISION MUST BE MADE FOR THE TRAINING OF PERSONNEL TO PROVIDE SUCH SERVICES NEEDED BY THE BLIND, THE DEAF, THE MENTALLY RETARDED AND OTHER SPECIAL CATEGORIES.
>
> It is our suggestion that where specialized agencies now exist they should be encouraged to continue pre-vocational services such as early education, and post-vocational services such as work activity and recreation. Where specialized agencies now maintain long-term or terminal workshops for clients with special disabilities they should be encouraged to serve individuals with other disabilities and to develop integrated workshops for those individuals unable to engage in competitive employment. Such workshops should engage in continuous screening and provide work-trial periods for those clients who might move into the competitive labor market.

Current regulations governing grants to private agencies under the Vocational Rehabilitation Administration Act require that when counting the number of clients served and rehabilitated within a 12-month period the count must be an unduplicated one. This is discrimination in favor of the state agency which can, where indicated, rehabilitate the same person more than once in any given year.

> THEREFORE IT IS RECOMMENDED THAT GRANT REQUIREMENTS BE MODIFIED SO THAT THE SAME STANDARDS FOR STATISTICAL REPORTING APPLY TO GRANT RECIPIENTS AS APPLY TO THE STATE AGENCY.

COORDINATION WITH OTHER STATE PLANNING

Representatives of other planning bodies have been members of this Committee, and have contributed to the planning effort for vocational rehabilitation. Such agencies as the Community Action Organization, Mental Health, Mental Retardation Planning, Vocational and Special Education, Hill-Burton Planning, Rehabilitation Workshops and Facilities Planning, and Comprehensive Health Planning have been represented. The Tompkins County Sub-Committee of Region IV prepared its report for Statewide Planning for Vocational Rehabilitation with the objective in mind that the same report could be utilized for Comprehensive Health Planning. One of the problems that confronted the Advisory Committee was the fact that planning areas differed for different planning groups, and the Committee therefore recommends that

> IN TERMS OF FUTURE PLANNING ALL DISTRICTS FOR ALL TYPES OF STATE PLANNING AND OPERATIONS BE THE SAME AS FAR AS POSSIBLE.

SPECIAL PLANNING TOPICS

Architectural Barriers

Noting that since the New York State recommendations for the elimination of architectural barriers were made, many buildings, particularly schools, were approved without correction of these barriers,

> IT IS RECOMMENDED THAT THE STATE ENCOURAGE BUILDING CODES WHICH EMPHASIZE THE IMPORTANCE OF ELIMINATING STRUCTURAL BARRIERS IN BUILDINGS THAT PREVENT MANY DISABLED FROM LEADING AN ORDINARY LIFE WITH REASONABLE INDEPENDENCE.
>
> This difficulty is most evident in non-governmentally owned buildings such as office buildings, restaurants, hotels, theatres, other places of recreation, churches, stores and the like.

Transportation

As has been previously noted, many rehabilitation facilities are underutilized because clients needing their services cannot reach them through the available means of transportation. Furthermore, rehabilitated clients capable of working in private industry often cannot be placed because of lack of transportation to and from the work site.

> IT IS RECOMMENDED THAT TRANSPORTATION SERVICE BE MADE AN INTEGRAL PART OF PROPOSALS OF VOCATIONAL REHABILITATION AGENCIES SEEKING GRANTS, AND THAT THE STATE VOCATIONAL REHABILITATION AGENCY SHOULD COORDINATE WITH THE JOT PROGRAM OF THE NEW YORK STATE EMPLOYMENT SERVICE TO UTILIZE THE NEWLY ESTABLISHED TRANSPORTATION SERVICES FROM THE INNER CITY TO JOB SITES.

Continued Planning and Follow-Up

Implementation of the Region IV plan will depend very largely upon the development of local resources. The District Committees have repeatedly emphasized that state and regional planning be subsidiary to local planning "in favor of getting to the grass roots." For example, certain less wealthy counties are unable to gain financial assistance from the state at present until the standards, which may be too high, are met. Such counties should be encouraged to develop small-scale innovative programs, be allowed more flexibility, and given assistance and consultation by the state to supplement limited local resources.

The Advisory Committee members have pointed out that local communities, if given the responsibility, are more likely to respond to community needs by the development of facilities and the creation of jobs both in the public and private sectors if the community makes its own plans.

> THE COMMITTEE RECOMMENDS THE DEVELOPMENT OF REPRESENTATIVE STRONG LOCAL ADVISORY BODIES.
>
> Such bodies should have representatives from all sectors of the local community including representatives from public and private agencies, labor, industry and the general public. Advisory Committees for Statewide Planning for Vocational Rehabilitation and the county and area committee should become permanent bodies for the continuous planning of community resources to meet needs. The Committee should also continue to function on a district and regional basis for the coordination of regional resources and interchange of information.

The need exists for continuous planning and review of proposals at the state level. While it is desirable to undertake long-range planning projects such as this one, it is recognized that the implementation of such a plan will require constant review and full-time staff at the state level to undertake the proposed reorganization. Furthermore, administrative aspects of the State Rehabilitation Agency will require planning, and procedures will need to be revised.

> THEREFORE THE COMMITTEE RECOMMENDS THAT THERE BE ESTABLISHED A SECTION OF THE STATE REHABILITATION AGENCY ADEQUATELY STAFFED TO CARRY ON MANAGEMENT STUDIES, RESEARCH IN METHODOLOGY, ANALYSIS OF SYSTEMS PROCEDURES, RECORDS AND CONTROLS.

This section shall also be responsible for evaluating outcomes and shall seek to standardize forms and eliminate unnecessary paper work wherever possible.

Research

The Committee wishes to emphasize the necessity for continuous research for the purpose of exploring the validity of existing methodologies and techniques, and for the purpose of discovering new approaches.

THE COMMITTEE RECOMMENDS THAT NO GRANTS FOR DEMONSTRATION OR PILOT PROJECTS BE MADE WITHOUT PROVISION FOR BUILT-IN PROGRAM EVALUATION AND RESEARCH AND THAT THE STATE VOCATIONAL REHABILITATION AGENCY MAKE AVAILABLE A CONTINUOUS CONSULTATION SERVICE TO ASSIST LOCAL COMMUNITIES IN THIS REGARD.

There are various areas in the rehabilitation process which need further exploration. The following areas are suggested as possible research projects:

- Systems studies of vocational rehabilitation organizations
- Studies of manpower training and utilization practices
- Studies of alternate approaches to operating service delivery systems
- Studies of service outcomes, including possible needs for after care or continuing care
- Studies of the impact of vocational rehabilitation services on the regional economy from a cost-benefit viewpoint

REFERENCES

1 "Mapping a Route for the Jobless", Business Week, June 22, 1968, p. 112

2 Office of the Assistant Secretary (Planning and Evaluation) U.S. Department, HEW, Human Investment Programs - Vocational Rehabilitation, Program Analysis (1967-13) Washington, D. C. 1967.

3 National Center for Health Statistics, Health Characteristics by Geographic Region, Large Metropolitan Areas, and Other Places of Residence, U.S. July 1963 - June 1965 (Series 10, No. 36)

4 Preliminary Estimate prepared by the Research Staff of the Office for Statewide Planning for Vocational Rehabilitation, based on Office of Planning Projections, June, 1968

5 New York State Education Department, Division of Vocational Rehabilitation, Progress Report on Statewide Planning for Workshops and Rehabilitation Facilities and Interim State Workshops and Rehabilitation Plan, Albany, N.Y., 1967

6 Temporary State Commission to Study and Investigate the Problems of the Deaf, The Minority Group Needs of the Deaf, Albany, N.Y., March 31, 1968

7 Office for Statewide Planning for Vocational Rehabilitation Services, General Handbook, Albany, 1967

8 Ryan, William, Distress in the City, A Summary Report of the Boston Mental Health Survey, 1960-62, Massachusetts Association for Mental Health, Boston, Massachusetts, 1966

9 Community Welfare Council of Buffalo and Erie County, The Community Alcoholism Project, Report and Recommendations, Buffalo, N.Y., November 28, 1966

10 Western New York School Study Council, The Nature of Poverty in Chautauqua County, Buffalo, New York, 1966

11 Migrant Ministry, National Council of Churches, Let Justice Roll, New York, New York, March, 1968

12 Popick, Bernard, "Social Security and Rehabilitation on the Move," Journal on Rehabilitation, May-June, 1967

13 Disraely, Seymour, "An Approach to a Problem in Compensation and Rehabilitation," unpublished report

14 New York State Senate Labor and Industry Committee, Report - Second Printing, Albany, New York, July 18, 1968